June 25, 2013

ADVANCE NOTICE OF INTENT TO FILE FOR READOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give a five working day advance notice of their intent to file for a readoption of emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to request OAL to approve the Exchange's readoption of the previously approved emergency regulations affecting the Exchange's contracting process and standards for selecting and contracting with Qualified Health Plans for the sale of health insurance through the Health Benefit Exchange starting October 1, 2013. The readoption of the existing emergency regulation would allow the Exchange an additional 90-day period in which to continue its progress toward adoption of permanent regulations. This action is being taken in accordance with Government Code Section 11346.1 and 11349.6 of the California Administrative Procedures Act and Title 1, California Code of Regulations section 52.

Pursuant to California Code of Regulations, title 1, section 52(c), the Exchange is incorporating by reference the rulemaking file, OAL File No. 2013-0111-02E, submitted January 11, 2012, for the initial adoption of the emergency regulations.

As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file for a readoption of the emergency regulations with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the emergency regulations currently in place (also enclosed), they must be received by both the Exchange and the Office of Administrative Law within five calendar days of the Exchange's filing at OAL. Responding to these comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange

Attn: Brandon Ross
560 J Street, Suite 290
Sacramento, CA 95814

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved.

Please contact Brandon Ross at 916-323-3502 or info@hbex.ca.gov if you have any questions concerning this notice.

FINDING OF EMERGENCY

The Executive Director of the California Health Benefit Exchange finds that an emergency exists and the need for immediate readoption of the emergency regulations is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety or general welfare.

With the readoption of the emergency regulations, the Director will be able to ensure that a sufficient number of health plans are selected for participation in the California Health Benefit Exchange, which will allow millions of Californians to purchase high quality, affordable health care for themselves and their families. Please note that this finding of emergency has not changed since initial OAL approval of the emergency regulations effective January 17, 2013.

DEEMED EMERGENCY

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." (Gov. Code, § 100504(a)(6)).

AUTHORITY AND REFERENCE

Authority: Government Code Section 100504.
Reference: Government Code Sections 100502, 100503, 100504, 100505, and 100507.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012, will be incorporated by reference in the proposed regulations.

The Standardized Plan Designs referenced in Section II. B. of the Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond have been promulgated through emergency regulations approved by OAL on March 29, 2013.

The previously approved emergency rulemaking file, file number 2013-0111-02E, is hereby incorporated into this rulemaking by reference.

Summary of Existing Laws

Existing law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange. The Exchange is responsible for arranging and contracting with health insurance issuers to provide affordable, quality health

insurance coverage to qualified individuals and qualified employers through the Exchange. (Gov. Code, § 100500 et seq.) In order to provide health care coverage through the Exchange, the Exchange must contract with health insurance issuers through a competitive selection process based on uniform standards and criteria that must be developed by the Exchange. (Gov. Code, §§ 100503, 100504).

The proposed regulations will provide the public with the clear standards and guidelines the Exchange will use in its selection of health insurance issuers for participation as qualified health plans in the Exchange. The regulations will ensure that all health plan issuers are on a level playing field and have an equal opportunity to be selected for participation in the Exchange. Additionally, these regulations will increase transparency in the Exchange's process for selecting qualified health plans, which will result in greater consumer confidence in the Exchange.

The proposed regulations will provide the framework for the Exchange to contract with health insurance issuers to offer health insurance coverage through the Exchange to millions of Californians. The proposed regulations will specifically benefit millions of Californians by providing them with the opportunity to purchase high-quality, affordable health insurance for themselves and their family members through the Exchange. The Exchange is the sole marketplace where Californians at certain income levels will be able to use federal tax credits to reduce the cost of their health insurance premiums and to purchase coverage that is eligible for federal subsidies that will reduce the cost-sharing requirements in their health plans. Without these proposed regulations, Californians would be unable to use federal tax subsidies for the purchase of health insurance through the Exchange.

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. The Exchange is the sole agency authorized to contract for the sale of qualified health plans through the California Health Benefit Exchange. As such there are no other regulations in existence that address the subject of these proposed regulations. Further, the proposed regulations are not inconsistent or incompatible with any other regulations that address health plans outside of the Exchange.

The proposed emergency rulemaking text in this readoption is the same as the text in the emergency rulemaking previously adopted by the Exchange in file number 2013-0111-02E.

Substantial Progress and Diligence in Compliance with Government Code § 11346.1(e)

The Exchange has made substantial progress and proceeded with diligence in complying with Government Code section 11346.1(e). However, these emergency regulations present a unique set of circumstances because they will no longer apply after August 2013. Up until August, the Exchange is relying on these regulations to evaluate and select numerous health plans to be certified as qualified health plans to be

offered on the Exchange. At this time, the Exchange is waiting on the Department of Managed Health Care and Department of Insurance to make their determinations that the plans selected by the Exchange are licensed and in good standing to offer their products in California. The Exchange anticipates this process will be completed by July 2013, at which time the Exchange will enter into contracts with each qualified health plan. Once the Exchange contracts with the qualified health plans, the selection process will be complete and the emergency regulations will no longer be necessary.

Although the Exchange will be selecting and evaluating qualified health plans again in the future, likely in 2014 or 2015, the standards and criteria will drastically change and the Exchange will be required to promulgate new regulations with those new standards. The Exchange will adopt new standards for years 2014 and beyond through a new emergency rulemaking, and subsequently, through the permanent rulemaking process.

Nevertheless, the Exchange has made substantial progress and proceeded with diligence in making these emergency regulations permanent in the chance that the Exchange will use these regulations beyond August 2013. Over the last several months, the Exchange's finance department has reexamined the fiscal impact on local and state government and estimated the economic impact these regulations will have on the private sector. The Exchange has spent the last few months assessing the impact the regulations will have on businesses and employees within the State of California as well as reassessing the impact on local and state government. A completed form 399 is attached hereto and is submitted with the rulemaking file.

Identifying the full economic and fiscal impact of these regulations will be the most time intensive aspect of making the emergency regulations permanent. If the Exchange determines it will use these regulations beyond August 2013, given the substantial progress the Exchange has made in furtherance of these emergency regulations, the Exchange will have ample time to complete the rulemaking process and make the regulations permanent. Therefore, a readoption of the emergency regulations is appropriate to determine if the regulations will be needed beyond August 2013, at which time, the Exchange will complete the regular rulemaking process.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

None.

LOCAL MANDATE

The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES (Attached Form 399)

This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

COSTS OR SAVINGS TO STATE AGENCIES (Attached Form 399)

The proposal results in additional costs to the California Health Benefit Exchange, which is funded by federal grant money. The proposal does not result in any costs or savings to any other state agency.

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		

For use by Office of Administrative Law (OAL) only

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
California Health Benefit Exchange

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
Process for Selecting Qualified Health Plans for the Exchange	2013-0111-02E and 2012-1127-03E

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT	AMEND	REPEAL
TITLE(S) 10	6410, 6420, 6422, 6424, 6440, 6442, 6444		

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Brandon Ross	916-323-3502		

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE

DATE 6/25/13

TYPED NAME AND TITLE OF SIGNATORY
Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

READOPT SECTIONS 6410, 6420, 6422, 6424, 6440, 6442, and 6444 to read:

ARTICLE 2: DEFINITIONS

SECTION 6410: DEFINITIONS

As used in this Chapter, the following terms shall mean:

340B Entity: A “covered entity” as defined in Public Health Service Act Section 340B(a)(4), 42 U.S.C. 256b(a)(4).

Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients’ use of primary care services. Characteristics of an ACO may include robust use of electronic health record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.

Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange’s Standardized Qualified Health Plan Designs.

Benefit Plan Requirements: Coverage that provides for all of the following as under 45 CFR § 156.20:

(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;
(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and
(c) A bronze, silver, gold, or platinum level of coverage as described in Section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by Government Code 100500.

CAHPS: Consumer Assessment of Healthcare Providers and Systems. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops

surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

CalHEERS: The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to Government Code 100502 and 100503, as well as 42 U.S.C. 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to Government Code 100500. The Exchange also does business as and may be referred to as “Covered California.”

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost-share: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Day: A calendar day unless a business day is specified.

EPO: An Exclusive Provider Organization, as defined in California Code of Regulations, title 10, Section 2699.6000(r).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235.

Essential Health Benefits: The benefits listed in 42 U.S.C. 18022, Health and Safety Code 1367.005, and Insurance Code 10112.27.

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the response.

Executive Director: The Executive Director of the Exchange.

Federally-Qualified Health Center (FQHC): Federally-Qualified Health Center has the same meaning as that term is defined in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)).

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103. Also referred to as "Health Issuer" or "Issuer."

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in Health & Safety Code 1345) holding a current license from and in good standing with the California Department of Managed Health Care.

HEDIS: Health Effectiveness Data and Information Set, a set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

HSA: Health Savings Account, as defined in 26 U.S.C. 223.

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to California Government Code § 100500 et seq. (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), 42 U.S.C. 18031(b) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 C.F.R. 155.410(b).

Internet Web Portal: The web portal made available through a link on the Exchange's website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically and which can be accessed directly at https://www.proposaltech.com/app.php/login.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in 42 U.S.C. 18022(d) and (e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

POS: Point of Service as defined in Health & Safety Code 1374.60.

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Preferred Provider Organization: A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified Employer: Qualified Employer has the same meaning as that term is defined in 42 U.S.C. 18032(f)(2) and 45 C.F.R. 155.710.

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, 42 U.S.C. 18021. If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 U.S.C. 18022(b)(1)(J).

Qualified Health Plan Solicitation or Solicitation: The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012.

Qualified Individual: Qualified Individual is an individual who meets the requirements of 42 U.S.C. 18032(f)(1) and 45 C.F.R. 155.305(a).

Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.

Rating Region: The geographic regions for purposes of rating defined in Health & Safety Code 1357.512 and Insurance Code 10753.14.

SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.

Solicitation Official: The Exchange's single point of contact for the Solicitation.

Standalone Dental Plan: A plan providing limited scope dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 U.S.C. 18022(b)(1)(J).

Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code 100504(c), as described in Solicitation Section II.B.1.

State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.

State Mandates: Health care benefits required to be covered by California statutes.

Telemedicine: The ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.

Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 100501, 100502, 100503, 100505

ARTICLE 3: COMPETITIVE PROCESS FOR SELECTING QUALIFIED HEALTH PLANS

SECTION 6420: 2012-2013 QUALIFIED HEALTH PLAN SOLICITATION

(a) Qualified Health Plan Solicitation. The Exchange will solicit bids from Health Insurance Issuers to offer, market, and sell QHPs through the Exchange beginning in the Initial Open Enrollment Period. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted bids and reserves the right to select or reject any Bidder or to cancel the Solicitation at any time for any reason. The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012, is hereby incorporated by reference.

(1) Bidders must be available before selection and certification by the Exchange to offer their QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and test data interfaces with CalHEERS, and to provide any additional information necessary for the Exchange to market, to enroll members, and to provide QHP services effective January 1, 2014.

Authority: Gov. Code §§ 100503, 100504, 100505
Reference: Gov. Code §§ 100503, 100505

SECTION 6422: BIDDER REQUIREMENTS

Health Insurance Issuers interested in offering, marketing, and selling QHPs through the Exchange must comply with and respond to the questions and information requested in the Qualified Health Plan Solicitation. A Health Insurance Issuer must comply with all requirements in the Qualified Health Plan Solicitation and meet all of the criteria listed in this Article in order to submit a bid in response to the Qualified Health Plan Solicitation.

Authority: Gov. Code §§ 100503, 100504
Reference: Gov. Code §§ 100503, 100507; 42 U.S.C. § 18021; 45 C.F.R. § 156.200

SECTION 6424: PROPOSAL PREPARATION INSTRUCTIONS

(a) Final response format and content

(1) For the development and presentation of response data, Bidders must adhere to all format instructions required by the Exchange in Solicitation Section III.

(2) Notwithstanding the above, a Bidder may explain in its response why it cannot respond to any given question or section of the Solicitation. The Exchange reserves the right to accept or reject such explanations at its sole discretion.

(3) The Exchange will make the entire Solicitation available through an Internet Web Portal where Bidders are required to submit their responses. Bidders' entire response must be submitted electronically. The Exchange will assign Bidders a login identification to access the Internet Web Portal, which can be accessed at https://www.proposaltech.com/app.php/login. Each Bidder must identify a primary Solicitation respondent, but that individual may, in turn, designate internal subject matter experts for responding. Bidders must participate in two training sessions conducted by the Exchange in order to submit a response to the Solicitation. The Exchange will provide Bidders with written documentation in support of their use of the Internet Web Portal at the training sessions.

(b) General instructions

(1) Each Bidder is limited to a submission of a single response to the Solicitation. For the purposes of this paragraph, "Bidder" includes a parent corporation of a Bidder and any other subsidiary of that parent corporation. If a Bidder submits more than one response, the Exchange will reject all responses submitted by that Bidder.

(2) Before submitting a response, Bidders may seek timely written clarification of any requirements or instructions in the Solicitation by submitting a written inquiry to the Exchange. Bidders must make these inquiries during the timeframe outlined in the Solicitation timeline in Section I. I. of the Solicitation.

(3) Bidders' responses must be delivered to the Solicitation Official by the date and time listed in Solicitation Section I. I. under Key Action Dates for response submission.

(4) Bidders' responses must be submitted in phases as indicated by the Exchange in Solicitation Section I. I.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505

SECTION 6440: EVALUATION

(a) Initial Selection: During initial selection, the Exchange Evaluation Team will check each response in detail to determine its compliance with the requirements in this Article. Failure to respond to or meet a mandatory requirement may result in the Exchange considering a Bidder's final response as non-responsive.

(b) Evaluation of Issuers: the Exchange Evaluation Team will consider the mix of QHPs that best meet the Exchange's goal of providing an appropriate range of high-quality choice to participants at the best available price in every part of California. Through its evaluation process, the Exchange will give greater consideration to proposed QHPs that promote the following:

(1) Affordability for the consumer and small employer – both in terms of premium and at point of care.

(2) "Value" competition based upon quality, service, and price.

(3) Competition based upon meaningful QHP choice and product differentiation.

(4) Competition throughout the state.

(5) Alignment with providers and delivery systems that serve the low-income population.

(6) Delivery system improvement, effective prevention programs and payment reform.

(7) Long-term partnerships between the Exchange and Health Insurance Issuers.

Authority: Gov. Code §§ 100502, 100503, 100504, 100505
Reference: Gov. Code §§ 100502, 100503, 100505

SECTION 6442: QHP CERTIFICATION

The Exchange will provide each successful Bidder with a certification that each health plan it offers in the Exchange is a QHP.

Authority: Gov. Code §§ 100502, 100504.
Reference: Gov. Code §§ 100502, 100503; 42 U.S.C. § 18031; 45 C.F.R. 156.200.

SECTION 6444: PROTEST PROCESS

(a) If a Bidder has submitted a proposal which it believes to be totally responsive to the Solicitation's requirements and believes the Bidder should have been selected as a successful Bidder, the Bidder may submit a protest of the selection as described below.

(b) All protests must be made in writing, signed by an individual who is authorized to contractually bind the Bidder, and contain a statement of the reason(s) for protest, citing the law, rule, regulation or procedure on which the protest is based. The Bidder must provide facts and evidence to support its claim. The Bidder must send its protest by certified or registered mail, unless delivered in person, in which case the protester should obtain a receipt of delivery. The Exchange must receive all protests by 5:00 pm on the fifth (5th) calendar day following Bidder selection.

(c) Protests must be mailed or delivered to:

California Health Benefit Exchange
Attn: Executive Director
560 J Street, Suite 290
Sacramento, CA 95814

(d) Protests will be heard and resolved by the California Health Benefit Exchange's Executive Director or his or her designee.

Authority: Gov. Code §§ 100502, 100504, 100505
Reference: Gov. Code §§ 100502, 100505

California Health Benefit Exchange

California Health Benefit Exchange

2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers

And Invitation to Respond

Qualified Health Plans Solicitation

For Individual and Small Business

Health Options Program (SHOP) Exchanges

Final Release - November 16, 2012

Amended on December 28, 2012

560 J Street, Suite 290, Sacramento, CA 95814
www.healthexchange.ca.gov

This page intentionally left blank.

Table of Contents

I. GENERAL INFORMATION AND BACKGROUND

A. PURPOSE

The California Health Benefit Exchange (Exchange) is soliciting responses from Health Insurance Issuers[1] (Bidders) to submit bids to offer, market, and sell qualified health plans (QHP) through the Exchange beginning in 2013, for coverage effective January 1, 2014. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted bids and reserves the right to select or reject any Bidder or to cancel the Solicitation at any time.

This is the final release of the Initial Solicitation to Health Issuers (the Solicitation). This release takes into consideration stakeholder comments. This release may be amended by addenda through the administrative rulemaking process, that may describe supplemental information required pertaining to standardized qualified health plan benefit design(s), pediatric vision and oral essential health benefits, and sections still under development, including model contract terms and additional evaluation criteria. Depending on future federal guidance and rules, QHP Bidders may be required to separate their bid for certain pediatric essential health benefits (dental or vision) from their bid for remaining essential health benefits. All addenda and additional requirements will be prescribed through the administrative rulemaking process at a later date. Issuers who have responded to the Notice of Intent to Bid will be issued a web login for on-line access to the final solicitation and will be notified via e-mail of the release of addenda or any subsequent instructions regarding the QHP solicitation.

The matter contained in this document is strictly related to the initial year Issuer QHP and stand-alone dental plan applications. The Exchange has not yet made decisions about the process for decertification and any related annual or other periodic recertification requirements. Requirements for recertification and decertification will be based on the certification requirements identified in this solicitation in addition to potential additional criteria to be prescribed through the administrative rulemaking process at a later date.

B. BACKGROUND

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Effective January 1, 2014, the California Health Benefit Exchange will be offering a statewide health insurance exchange to make it easier for individuals and small

[1] The term “Health Issuer” used in this document refers to both health plans regulated by the California Department of Managed Health Care and insurers regulated by the California Department of Insurance. It also refers to the company issuing health coverage, while the term “Qualified Health Plan” refers to a specific policy or plan to be sold to a consumer. Qualified Health Plans are also referred to as “products”. The term "Bidder" refers to a Health Insurance Issuer who is seeking a Qualified Health Plan contract with the Exchange.

businesses to compare plans and buy health insurance in the private market, with enrollment beginning in fall 2013. Although the focus of the Exchange will be on individuals and small businesses who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with fewer than 50 employees.

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

- **Consumer-Focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.

- **Affordability**: The Exchange will provide affordable health insurance while assuring quality and access.

- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.

- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

The Exchange needs to address these issues for the millions of Californians who will enroll through it to get coverage, but also must be part of broader efforts to improve care, improve health, and control health care costs.

California has many of the infrastructure elements that will allow the Exchange to work with health plans, clinicians, hospitals, consumer groups, purchasers and others as partners to support the changes needed to achieve the triple aim of better care, better health, and lower cost. These include the state's history of multispecialty and organized medical groups, the presence of statewide and regional managed care health maintenance and preferred provider organizations, public reporting of health care information and delivery system performance, and active efforts by public and private sector payers to test new and innovative models of care delivery and payment reform.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans that will be offered in the Exchange.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health plan Issuers.[2]

These concepts, and the inherent trade-offs among the California Health Benefit Exchange values, must be balanced in the evaluation and selection of the Qualified Health Plans that will be offered on the Individual and the SHOP Exchanges.

As outlined in the Board Options and Recommendations Briefs for Qualified Health Plan Policies and Strategies, the QHP selection will influence how competitive the market will be, the cost of coverage, and strategies to add value through health care delivery system improvement. The Board Options and Recommendations Briefs for Qualified Health Plan Policies and Strategies can be referenced at; http://www.healthexchange.ca.gov/BoardMeetings/Documents/August_23_2012/IX_FinalBRB-QHPPoliciesandStrategies_8-23-12.pdf

Important issues include how much to standardize the individual and small group market rating rules and the benefits and member cost-sharing for the Exchange plans, how many and what type of products are offered, what reporting and quality standards the plans must meet, and how to build upon and encourage innovation in both health care delivery and payment mechanisms.

C. Evaluation of Issuers QHP Bids and Selection and Oversight of QHPs

The evaluation of QHP bids will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the Exchange's goals. The Exchange wants to provide an appropriate range of

[2] California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).

high quality plan to participants at the best available price. In consideration of the mission and values of the Exchange, the Board of the Exchange articulated guidelines for the selection and oversight of Qualified Health Plans in August 2012 which will be considered in the review of QHP bids. These guidelines are:

Promote affordability for the consumer and small employer – both in terms of premium and at point of care

The Exchange seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers in terms of premiums and at the point of care, while fostering competition and stable premiums. The Exchange will seek to offer health plans, plan designs and provider networks that will attract maximum enrollment as part of the Exchange's effort to lower costs by spreading risk as broadly as possible.

Encourage "Value" Competition Based upon Quality, Service, and Price

While premium and out-of-pocket costs for consumers will be a key consideration, contracts will be awarded based on determination of "best value" to the Exchange and its participants. The Phase 1 evaluation of Issuer QHP bids will focus on quality and service components, including past history of performance, reported quality and satisfaction metrics, quality improvement plans and commitment to serve the Exchange population through cooperation with the Exchange operations, provider network adequacy, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements and payment reform. We expect that some necessary regulatory and rate filings may need to be completed after the due date for this QHP solicitation. The solicitation responses, in conjunction with the approved filings, will be weighted to develop a measure of overall "value" that will be used as part of the selection of the initial health plans that will be offered on the Exchanges.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Standard and Non-Standard Benefit Plan Designs[3]

The Exchange is committed to fostering competition by offering QHPs with features that present clear choice, product and provider network differentiation. Through a future administrative rulemaking, QHP Bidders will be required to bid at least one of the Exchange's adopted standardized benefit plan designs (either co-pay or co-insurance plan) in each region for which they submit a bid. In addition, QHP Bidders may propose an alternative benefit design and may offer the Exchange's standardized Health Savings Account-eligible (HSA) design. The standardized benefit plan designs use cost sharing provisions that are predominantly deductibles with either co-payments ("co-pay plan") or co-insurance ("co-insurance plan") and are intended to be "platform neutral". That is, either of the standardized benefit designs can be applied to a network product design that may be a health maintenance organization (HMO) or exclusive provider organization (EPO) with out-of-network benefits limited to pre-authorized and emergency services, or to Preferred Provider Organization (PPO) or Point of Service (POS) product design that

[3] The Standard Benefit Designs will be released as an Addendum to this Solicitation through the administrative rulemaking process at a later date. The Exchange will likely make minor modifications to the cost-sharing provisions of its standard benefit plan designs when the anticipated federal actuarial value calculator is released. All modifications or changes to the requirements herein will be prescribed through the administrative rulemaking process.

offer out-of-network coverage with significantly higher levels of member cost-sharing. To the extent possible, both HMO and PPO products will be offered. If there are meaningful differences in network design, levels of integration, and other innovative delivery system features, multiple HMO or PPO products will be considered in the same geographic service area. Within a given product design, the Exchange will look for differences in network providers and the use of innovative delivery models. Under such criteria, the Exchange may choose not to contract with two plans with broad overlapping PPO networks within a rating region unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

The Exchange must be statewide. Issuers are encouraged to submit QHP bids in all geographic service areas in which they are licensed, and preference will be given to Issuers that develop QHP bids that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state as well as the more densely populated areas.

Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population

Central to the Exchange's mission is its doing effective outreach, enrollment and retention of the low income population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange. Responses that demonstrate an ongoing commitment or have developed the capacity to serve the cultural, linguistic and health care needs of the low income and uninsured populations, beyond the minimum requirements adopted by the Exchange, will receive additional consideration. Examples of demonstrated commitment include the Bidder having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution that is reasonably distributed, contracts with Federally Qualified Health Centers, and support or investment in providers and networks that have historically served these populations in order to improve service delivery and integration.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of the Exchange is to serve as a catalyst for the improvement of care, prevention and wellness and reducing costs. The Exchange wants QHP offerings that incorporate innovations in delivery system improvement, prevention and wellness and/or payment reform that will help foster these broad goals. These may include various models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care. QHP bids that incorporate innovative models, particularly those with demonstrated effectiveness and a track record of success, will be preferred.

Encourage Long term Partnerships with Health Plan Issuers

A goal of the Exchange is to reward the early participants in the Exchange with contract features that offer a potential for market share and program stability that will encourage Issuer interest in multi-year contracts and provide incentives submitting rates at the most competitive position possible, foster rate and plan stability and encourage QHP

investments in product design, network development, and quality improvement programs. Solicitation responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission, including proposals for multi-year contracts are strongly encouraged, particularly those that may propose multi-year contracts that include underserved service areas, premium guarantees or proposed formula caps, and that leverage Issuer efforts to provide better care, improve health, and lower cost.

D. AVAILABILITY

The QHP Bidder/Issuer must be available immediately upon certification as a QHP to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide health plan services effective January 1, 2014. Successful Bidders will also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with CalHEERS. The Exchange expects to negotiate and sign contracts prior to June 1, 2013. The successful Bidders must be ready and able to accept enrollment as of October 1, 2013.

E. SOLICITATION PROCESS

The solicitation process shall consist of the following steps:

- Release of the Draft Solicitation;
- Comments due on Draft Solicitation;
- Release of the Final Solicitation;
- Questions from Bidders due to the Exchange;
- Exchange responds to Bidder questions;
- Submission of Bidder responses Phase 1;
- Submission of provider network data by Bidders Phase 2;
- Submission of price proposal by Bidders: Phase 3;
- Evaluation and selection of winning responses;
- Discussion and negotiation of final contract terms, conditions and premium rates;
- Execution of contracts with the selected QHP Issuers.

Phase 1 requires all responses to the Solicitation except price proposals and provider network submissions.

Phase 2 requires responses to all provider network requirements.

Phase 3 requires price proposals. Only Bidders who have successfully completed Phases 1 and 2 will be invited to submit price proposals.

F. CLARIFICATION QUESTIONS

Bidders may submit questions in writing, including via email, to the Solicitation Official listed in Section J of this solicitation. Bidders are encouraged to submit their questions early in the solicitation process to provide the Exchange with sufficient time to respond. The Exchange will attempt to answer all Bidder questions, but the Exchange is not required to respond and makes no guarantee that it will respond to Bidders' questions. The Exchange reserves the right to respond only to questions submitted by Bidders that submit a non-binding Letter of Intent to Bid (see Section G). Bidders shall provide specific information to enable the Exchange to identify and respond to their questions. At its discretion, the Exchange may contact an inquirer to seek clarification of any inquiry received. Bidders that fail to report a known or suspected problem with the solicitation, or that fail to seek clarification and/or correction of the solicitation, submit responses at their own risk.

G. INTENTION TO SUBMIT A RESPONSE

Bidders interested in responding to this solicitation are required to submit a non-binding Letter of Intent to Bid indicating their interest in bidding and their proposed products, service areas and the like and to ensure receipt of additional information. Only those Bidders acknowledging interest in this solicitation by submitting a notification of intention to submit a bid will continue to receive solicitation-related correspondence throughout the solicitation process. The Exchange intends to select QHPs for the initial year of operation with a strong interest in pursuing multi-year contracts with successful Bidders and may conduct a very limited second or third year solicitation process.

The Bidder's notification letter must identify the contact person for the solicitation process, along with contact information that includes an email address, a telephone number, and a fax number. Receipt of the non-binding letter of intent will be used to issue instructions and login and password information to gain access to the on-line portion(s) of the Bidder submission of response to the Solicitation.

An Issuer's submission of an Intent to Bid will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about Issuers' responses. Final Bidder information is not expected to be released until selected Issuers and QHP bids are announced in the second quarter of 2013. Confidentiality is to be held by the Exchange; Bidder information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators. The Exchange will discuss with the regulators the legal standards and feasibility of maintaining confidentiality of rate filings as they are submitted.

The Exchange will correspond with only one (1) contact person per Bidder. It shall be the Bidder's responsibility to immediately notify the Solicitation Official identified in Section J, in writing, regarding any revision to the contact information. The Exchange shall not be responsible for solicitation correspondence not received by the Bidder if the Bidder fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

H. SOLICITATION LIBRARY

Bidders may access the Solicitation Library at: http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf.

The Solicitation Library will allow Bidders access to reference documents and information that may be useful for developing the Bidder's response. The Solicitation Library will continue to be updated as further documentation related to the solicitation becomes available. Amendments to this Solicitation will not be issued when new information is posted to the Solicitation Library. Bidders are encouraged to continuously monitor the Solicitation Library, but are not required to access or view documents in the Solicitation Library.

The Exchange makes no warrantees with respect to the contents of the Solicitation Library and requirements specified in this solicitation take precedence over any Solicitation Library contents.

I. KEY ACTION DATES

Listed below is a series of key actions related to this solicitation, along with the corresponding dates and times by which each key action must be taken or completed. If the Exchange finds it necessary to change any of these dates, such changes will be accomplished through an addendum to this solicitation through the administrative rulemaking process at a later date. All dates subsequent to the final response submission deadline are approximate and may be adjusted as conditions warrant, without addendum to this solicitation.

Action	Date/Time
Release of Draft Solicitation	09/25/2012
Release of Revised Draft Solicitation	10/23/2012
Release of Final Solicitation	11/14/2012
Submission of bidder responses Phase 1 (5:00 pm PST)	01/23/2013
Submission of Attachments in Appendix II, Addendum #1 (5:00 pm PST)	01/31/2013
Submission of Essential Community Provider Network Information (Attachments in Appendix II, Addendum #2)	No later than 2/15/2012
Submission of provider network documents to regulators; Phase 2	No later than 2/28/2013
Submission of price proposals: Phase 3	No later than 3/31/2013
Evaluation and selection of winning responses	1/23/2013 - 4/01/2013
Discussion and negotiation of final contract terms, conditions, and premium	4/1/-5/31/2013
Execute contracts with certified Qualified Health Plans.	No later than 06/30/2013

J. SOLICITATION OFFICIAL

The Solicitation Official is the single point of contact for this solicitation. Please submit all correspondence to:

Andrea Rosen
The California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814
Office: 916.323.3480
Email: Andrea.Rosen@hbex.ca.gov

K. PROTEST PROCESS

A protest may be submitted according to the procedures set forth below. If a Bidder has submitted a proposal which it believes to be totally responsive to the requirements of the solicitation process and believes the Bidder should have been selected, according to Section IV.C - Evaluation of Final Reponses, the Bidder may submit a protest of the selection as described below. Protests will be heard and resolved by the California Health Benefit Exchange's Executive Director or his or her designee.

All protests must be made in writing, signed by an individual who is authorized to contractually bind the Bidder, and contain a statement of the reason(s) for protest, citing the law, rule, regulation or procedures on which the protest is based. The protester must provide facts and evidence to support its claim. Certified or registered mail must be used unless delivered in person, in which case the protester should obtain a receipt of delivery. The final day to receive a protest is five (5) calendar days after Bidder selection. Protests must be mailed or delivered to:

Street Address	Mailing Address
California Health Benefit Exchange	California Health Benefit Exchange
Attn: Peter Lee, Executive Director	Attn: Peter Lee, Executive Director
560 J Street Suite 290	560 J Street Suite 290
Sacramento, CA 95814	Sacramento, CA 95814

II. TECHNICAL REQUIREMENTS

A. REGULATORY COMPLIANCE: LICENSED AND IN GOOD STANDING AND REGULATORY FILINGS

1. COVER PAGE

a) ***Bidder must complete the Bidder Information Cover Page using the template in Appendix I, Addendum 1.***

2. LICENSED AND IN GOOD STANDING

a) ***In addition to holding all of the proper and required licenses[4] to operate as a health plan Issuer as defined herein, the Bidder must indicate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the Bidder has had no material fines, penalties levied, citations, or ongoing disputes with applicable licensing authorities in the last two years.***

Bidder must check the appropriate box. If Bidder checks "Yes", you are indicating that you are in good standing with all appropriate licensing authorities as specified above. If Bidder checks "No", you are indicating that you are not in good standing. If no, the bid will be disqualified from consideration.

___Yes

___No (explain)

b) ***Does your organization have any ongoing labor disputes, penalties, fines, or corrective action citations for federal or state workplace safety issues? If yes, indicate whether these will be addressed by the date bids are due Bidder must check the appropriate box. If yes, provide an explanation.***

___Yes (explain)

___No

c) ***Provide details of the Key Personnel and representatives of the Account Management Team who will be assigned to the California Health Benefit Exchange.***

[4] The Exchange reserves the right to require licenses to be in place at the time of QHP selection in the case of new applicants for licenses. Bidders who are not yet licensed should indicate anticipated date of licensure.

Bidder must include an organizational chart, description of roles, and resumes of key personnel who will be assigned to the California Health Benefit Exchange.

	Contact Name	Title	Phone (include extension)	Fax	E-mail
President or CEO	*100 words.*	*100 words.*	*100 words.*	*Unlimited.*	*Unlimited.*
Chief Medical Officer	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
SVP, Small Group	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
SVP, Individual	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Chief Actuary (Lead for Exchange Rate Development)	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Lead for Exchange Strategy	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Lead Account Manager for Exchange	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
SVP, Provider Network Management	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
SVP, Government Affairs	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.
Other	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.

3. NEW APPLICATION OR MATERIAL MODIFICATION OF AN EXISTING LICENSE OR AMENDMENT TO A CERTIFICATE OF AUTHORITY

a) ***Bidder must indicate if Bidder is an applicant for a new license or material modification to an existing license from the California Department of Managed Health Care OR indicate if the Bidder is seeking a certificate of authority or an amendment to an existing certificate of authority from the California Department of Insurance in order to meet the requirements of individual and small group products to be offered both on the California Health Benefit Exchange.***

Bidder must check the appropriate box. If Bidder checks "Yes", you are indicating that you have submitted an application for a new license or material modification of a current license to the regulatory authorities or for a certificate of authority or an amendment as part of your organization's response to the solicitation. If Bidder checks "No", you are indicating that you have not submitted an application for a new license or material modification of a current license to the regulatory authorities as part of your response to this solicitation. If yes, Bidder must respond to the questions that follow.

___Yes (explain)

___No

If yes, Bidder must indicate type of filing _____and complete the information below.

Original application for a plan license or certificate of authority.
Regulatory Agency_____
Regulatory Filing No. ____.
Date of Submission. ____.
Expected Date for Review/Approval. ____.

Amendment # ____ to a pending license application or amendment to certificate of authority initially filed on ___,
2nd, 3rd, etc.
Regulatory Agency_____
Regulatory Filing No. ____.
Date of Submission. ____.
Expected Date for Review/Approval. ____.

Notice of a proposed material modification
Regulatory Agency_____
Regulatory Filing No. ____.
Date of Submission. ____.
Expected Date for Review/Approval. ____

OTHER CATEGORIES?
Regulatory Agency_____
Regulatory Filing No. ____.
Date of Submission. ____.
Expected Date for Review/Approval. ____

4. QUALIFIED HEALTH PLAN REGULATORY COMPLIANCE

a) ***Separate from the Bidder's response to this solicitation, a Bidder must submit all materials to the California regulatory agency necessary to obtain approval of product/plan and rate filings that are to be submitted in response to this solicitation. Bidder must indicate product and rate filings that have been submitted for regulatory review that you intend to submit as a QHP bid and include documentation of the filings as part of the response to this solicitation. If filings are not complete, the Bidder must update the Exchange with such information as it is submitted for regulatory review.***

b) ***The California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) have primary responsibility for regulatory review and issuing preliminary recommendations to the Exchange of certain selection criteria listed below in the definition of good standing in addition to applying the minimum licensure requirements. All licensure, regulatory and product filing requirements of DMHC and CDI shall apply to QHPs offered through the Exchange. Issuers must adhere to California insurance laws and regulations including, but not limited to, those identified in the roster of Good Standing elements that follow. Bidders must respond to questions raised by the agencies in their review. The agencies will conduct the review of:***

Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for what lines of business (e.g. commercial, small group, individual)	DMHC
• Approved to operate in what geographic service areas	DMHC
• Most recent financial exam and medical survey report	DMHC
•Most recent market conduct exam	CDI
Affirmation of no material[5] statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:	
• Financial solvency and reserves	DMHC and CDI
• Administrative and organizational capacity	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits[6] (as of 2014)	DMHC and CDI
• Basic health care services	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (classification of metal level as of 2014)	DMHC and CDI
• Network adequacy and accessibility standards	DMHC and CDI
• Provider contracts	DMHC and CDI
• Language Access	DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
• Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Independent medical review	DMHC and CDI
• Marketing and advertising	DMHC and CDI
• Guaranteed issue individual and small group (as of 2014)	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions[7]	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

[5] Material violations are those that represent a relevant and significant departure from normal business standards that a health plan issuer is expected to adhere to.
[6] Certain listed items, such as essential health benefits and actuarial value, are not required until 2014.
[7] The Exchange adopts the rating regions enacted for Small Group for use in the Individual Market until further legislation is enacted.

- Reasonableness Review

5. BIDDER REQUIREMENT REGARDING CALHEERS ENGAGEMENT AND TESTING

The eligibility, enrollment and retention information technology system used by the Exchange ("CalHEERS" – the California Healthcare Enrollment, Eligibility and Retention System) is in the process of being designed and tested.

a) Bidders must be prepared and able to engage in working with the Exchange to develop data interfaces between the Issuer's systems and the Exchange's systems, including CalHEERS as early as January 2013.

b) Bidders must provide comments on the requested data formats for interfaces between the Issuer's systems and the Exchange's systems in a timely fashion.

c) Bidders must be available for testing data interfaces with the Exchange no later than April 1, 2013.

B. CALIFORNIA HEALTH BENEFIT EXCHANGE QUALIFIED HEALTH PLAN QUESTIONS

1. PLAN NETWORK DESIGN ISSUES[8]

Bidder must certify that for each rating region in which it submits a health plan bid, it is submitting bids for all four metal level tiers and a catastrophic plan for each QHP (plan or insurance policy) it proposes to offer (except for an approved alternate plan design). Through a future administrative rulemaking, a QHP bid will be required to include at least one of the standardized plan designs and use the same provider network for each type of standard plan design in a family of plans or insurance policies for specified metal level actuarial values. **Note that the Exchange has adopted the small group rating regions definition in California Health and Safety Code Section 1357.512 and California Insurance Code Section 10753.14, as established in AB 1083, chapter 852 as of September 30, 2012, for the Individual Market until further legislation is enacted.**

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system

[8] The Standard Benefit Plan Designs will be released as an Addendum to this Solicitation through a future administrative rulemaking. The Exchange will likely make minor modifications to the cost-sharing provisions of its standard benefit plan designs when the anticipated final federal actuarial value calculator is released, which will also be prescribed through the administrative rulemaking process.

reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability and prevention.

Pediatric Vision Essential Health Benefit: If future federal rules permit a stand-alone plan for this benefit, QHP Bidders may be required through a future administrative rulemaking to offer QHPs which exclude the pediatric vision essential health benefit.

a) ***Through a future administrative rulemaking, QHP Bidders will be required to do the following: Plan or policy submission requirements: 1) QHP Bidders must submit either the "co-pay" or "co-insurance" standard plan design or a combination of the standard plan designs in order to offer all four metal levels and a catastrophic plan in its proposed rating regions. 2) QHP Bidders may submit proposals for both standard benefit plan designs and the Health Savings Account-eligible standardized design and 3) QHP Bidders may submit proposals for the coinsurance and/or copay standardized design, with or without the HSA-eligible design, and an alternative design. Standard benefit plan designs including the co-pay and co-insurance and HSA high deductible plan which specify standard cost-sharing requirements will be issued as part of a future rulemaking.***

For example, a QHP Bidder can propose either the "co-pay" or "co-insurance" standard designs in all metal levels and catastrophic or a combination of standard benefit plan designs as long as all metal levels are covered. Or it could submit both standard plan designs. Or it could submit both co-pay and co-insurance plans plus the "HSA" plans and a plan-specific alternative design.

Check the appropriate box. If Bidder checks "Yes", you are certifying each health product (plan) bid is submitted for all four metal level tiers (bronze, silver, gold, and platinum) and catastrophic for each plan it proposes to offer in a rating region. If Bidder checks "No", you are indicating that you are not submitting a bid for all four metal level tiers (bronze, silver, gold and platinum) and catastrophic for each plan it proposes to offer in a rating region. If no, the Bidder's response will be disqualified from consideration. Certification of the actuarial value of each QHP product tier will be performed by the relevant regulatory agency

___Yes

___No

If yes, Bidder must complete Appendix II, Addendum 1, Attachments 1.1 and 1.3 (SHOP) and 1.2 and 1.4 (Individual) to indicate the rating regions and number and type of plans for which you are proposing a QHP bid.

b) ***Two-Tier networks are allowed to overlay standard benefit plan designs. A Two-Tiered Network is defined as a benefit design with two in-network benefit levels. Standard plan cost-share is applied to the***

most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

c) ***In addition to standardized benefit design products which will be required through a future administrative rulemaking, the Bidder may submit one (1) alternate benefit design product for the rating region. The alternate benefit design must be offered at the silver level but is not required to be offered at all metal levels (including catastrophic); any alternate benefit design must represent a product family using the same network or network approach across all actuarial values. Use Appendix II, Addendum 1, Attachments 1.7 and 1.8 to submit all cost-sharing and other details for proposed alternate benefit plan designs. The Exchange is not necessarily encouraging alternate benefit plan designs and will carefully scrutinize such proposals.***

Alternate designs must be offered at the silver level but are not required to be offered at all metal levels. Alternate designs may be submitted for less than the full geographic service area for which the Bidder is licensed.

___Yes

___No

If yes, complete Appendix II, Addendum 1, Attachments 1.7 and/or 1.8 to indicate benefits and member cost sharing design for each alternate benefit plan design you propose. In completing the matrix, Bidder may insert text to:

(1) Indicate any additional or enhanced benefits relative to EHB

(2) Confirm all plans other than catastrophic include pediatric oral and vision EHB

(3) Indicate whether bid includes stand-alone dental product(s)

(4) If in-network tiers are proposed, describe the structure for hospital or provider tiers.

Bidders may propose High Deductible Health Plans with Health Savings Accounts using the standard benefit plan design provided by the Exchange to be issued in a future rulemaking procedure.

d) ***Bidder must certify that for each rating region in which it submits a health plan bid, it is submitting a bid that covers the entire geographic service area for which it is licensed within that rating region.***

___Yes

___No

Complete Appendix II, Addendum 1, Attachment 1.5 to indicate which zip codes are within the licensed geographic service area by type of platform and proposed Exchange product.

e) Partial Geographic Service Area in Rating Region Bid: An Issuer that is licensed to serve an entire rating region or a "substantial majority" of a rating region may submit a bid that includes less than the full geographic service area for which it is licensed in a rating region if 1) it submits a QHP bid for the rating region that includes the entire geographic service area for which it is licensed and 2) the partial rating region bid is for a different product design. A different product design is defined as a product which differs in covered services and/or member cost sharing for in-network providers. Products that differ only by limiting the provider network to those providers located in the partial geographic service area will not be considered a different product and must be bid at the same premium as the product that is offered for the entire geographic service area for which the Issuer is licensed in the rating region. The Issuer's full rating region QHP bid must be selected for the Exchange to consider a partial geographic service area in rating region bid by the Issuer.

Issuer is submitting a partial rating region bid:

___Yes

___No

If yes, provide a map that presents the proposed partial geographic service area compared to the licensed service area for each rating region in which the Issuer is submitting a partial geographic service area QHP bid.

f) Cost Proposal: Preliminary Premium Bids. Final negotiated and accepted premium bids shall be in effect for the first full year of operation of the Exchange, effective January 1, 2014, or for the SHOP plan year. Premium bids are considered preliminary and may be subject to negotiation as part of QHP certification and selection. The final negotiated premium amounts are expected to align with the product rate filings that will be submitted to the regulatory agencies in conjunction. Cost proposals will be due during Phase 2. When standard plan designs are final and issued in a future rulemaking, QHP bidders will be provided with an attachment to use for premium bidding purposes. Premium may vary only by geography (rating region), by age band (within 3:1 range requirement), by coverage tier, and by actuarial value metal level. Premium quotes for Child only and family coverage tiers that include child coverage must include a vision child essential health benefit. Premium quotes for Child only and family coverage tiers that include child coverage must provide two quotes: 1) one with pediatric dental essential health benefit and 2) one without pediatric dental essential health benefit.

g) Delivery System Reform: In keeping with its mission and values, the Exchange is charged with encouraging delivery system reforms which increase quality and consumer choice, lower cost and improve health. Complete Appendix II, Addendum 1, Attachment 1.6 by indicating which delivery system reforms your QHP bid will feature in which geographic regions and whether those products will be available to the Exchange in 2014, 2015 or not at all.

2. HEALTH PLAN PROVIDER NETWORK ADEQUACY

a) ***Bidder must certify that for each rating region in which it submits a health plan bid, the proposed products meet provider network adequacy standards established by the relevant regulatory agency. Provider network adequacy will be evaluated by the governing regulatory agency.***

___Yes

___No (explain)

3. ESSENTIAL COMMUNITY PROVIDER NETWORK GEOGRAPHIC SUFFICIENCY

a) ***Bidder must demonstrate that its QHP bids meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. All of the below criteria must be met.***

i. Qualified Health Plan Bidders must demonstrate sufficient geographic distribution of essential community providers (ECP) reasonably distributed throughout the Bidder's proposed geographic service area, with a balance of hospital and non-hospital providers. Bidders must list contracts with all providers designated as ECP and indicate the category of each contracted essential community provider (e.g. 340B or DSH hospital or HI-Tech provider, etc.) and demonstrate sufficient geographic distribution of essential community providers reasonably distributed throughout each county in the geographic service area; **AND**

ii. Bidders must demonstrate contracts with at least 15% of 340B entities per proposed geographic service area; **AND**

iii. Bidders must include at least one ECP hospital per proposed geographic service area. **AND**

iv. Application of above criteria for determination that an essential community provider network meets the standard of sufficient geographic distribution with a balance of hospital and non-hospital providers and serves the low-income population within the proposed geographic service area requires the Bidder to apply all three criteria interactively. The Exchange will evaluate the application of

all three criteria to determine whether the Bidder's essential community provider network has achieved the sufficient geographic distribution and balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of low-income population throughout the county that are not served by the contracted ECP hospital.

- The Exchange will consider school-based health centers ECPs. To the extent these centers have the capacity to contract with Issuers and generate claims, the Exchange encourages contracting and will count school-based health centers towards the 15% threshold.

- The Exchange will consider essential community provider networks that include county hospitals more favorably.

- Essential community provider networks which include more Federally Qualified Health Centers as contracted are preferred and will be considered more favorably.

Federal rules currently require health issuers to adhere to rules regarding payment to non-contracted FQHCs for services when those services are covered by the QHP's benefit plan. Certified QHPs will be required in their contract with the Exchange to operate in compliance with all federal rules issued pursuant to the Affordable Care Act, including those applicable to essential community providers. Bidders must use the county low income population data to submit the following geo-maps of each county within the proposed geographic service area (county maps may be aggregated for the service area).

1. ECP non-hospital providers plotted on a low-income population map, by county.
2. ECP hospital providers plotted on a low-income population map, by county.

Staff model and integrated delivery systems must demonstrate a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals. If existing provider capacity does not meet the criteria, the Bidder may be required to provide additional contracted or out-of-network care. Organizations that believe they qualify for an exemption from the Exchange 340B Essential Community Provider contracting requirement must explain how they will assure access for low-income, medically underserved individuals and are required to map their non-hospital and hospital providers against the low income population data.

Bidders shall complete Appendix II, Addendum 2, Attachments 2.1 through 2.7, which demonstrate the number and percentage of contracts with 340B providers by county within the proposed geographic service area.

- Attachments 2.1 and 2.2. Include name(s) of 340B entity contracted and all service sites affiliated with each contracted 340B entity. Only include site locations for a 340B entity if such site is included under the terms of the Issuer-provider contract. Please complete the contracted provider listing data elements using the supplied format in Attachments 2.1 and 2.2

- Attachments 2.3 through 2.7. Identify percentage of contracted 340B entities located in each county of the proposed geographic service area for each product offering. All 340B entity service sites shall be counted in the denominator, in accordance with the HRSA 340B provider site listing/link, which can be found at: http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf

  Categories of Essential Community

  Appendix III provides the Types and Lists of Essential Community Providers, which includes the following:

  1. 340B providers list as of November 9, 2012.
  2. California Disproportionate Share Hospital Program, Final DSH Eligibility List FY [CA DHCS 2011-12]
  3. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs
  4. Community Clinic or health center licensed as either a “community clinic” or “free clinic”, by the State of California under Health and Safety Code section 1204(a), or is a community clinic or free clinic exempt from licensure under Section 1206
  5. Providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program
  6. Essential Community Providers by County. This document provides county data on distribution of California Low-Income Population. Low-income is defined as a family at or below 200% of Federal Poverty Level. The data supplied will allow Bidders to plot contracted ECP locations on county maps which display the low-income population.

4. QUALITY IMPROVEMENT STRATEGY-PROMOTING BETTER CARE, BETTER HEALTH, AND LOWER COST

a) As part of a Quality Improvement Strategy, identify the mechanisms the Bidder intends to use to promote improvements in health care quality, better prevention and wellness and making care more affordable. These mechanisms may include plan designs that reduce barriers or provide incentives for preventive or wellness services by any of the means listed in the "Financial Incentives" column. In the "Product Availability" column, indicate the plan product types in which the incentive feature will be available. Check all that apply. Account-based means consumer-directed health plan with a health reimbursement account or a high deductible health plan with a health savings account. For "Product availability" column, Bidder should select all platforms on which the indicated financial incentives will be in place.

All Bidders are required to offer a Health Assessment[9] to members after enrollment, and to report to the Exchange the aggregated results of those members who complete assessments. The Exchange will give more weight to those responses from Bidders that offer Preventive and Wellness programs to members in both the Individual and the SHOP Exchanges. However, financial incentives may be offered only to members who enroll through the SHOP Exchange. Consistent with California law, the California Health Benefit Exchange intends to apply to be an approved pilot site for the use of preventive and wellness incentives for members who enroll through the Individual Exchange. Section 5.2 in eValue8 is a report on past experience.

The Exchange will give more weight to those responses from Bidders that engage in programs that foster payment and other practices that encourage primary care, care coordination, quality improvement, promoting health equity and reducing costs.

Bidders must describe their past or current initiatives in these areas in the sections that follow and in the eValue8 sections.

Preventive and Wellness Services	Product Availability	Available in Individual Exchange	Available in SHOP Exchange	SHOP Exchange Financial Incentives
Incentives contingent upon member behavior	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured HDHP,HSA eligible 3: Subject to additional fees	***N/A***	*Yes/No*	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced employee premium share and increased employer premium share contingent upon completion/participation. Health Plan premium rates remain unchanged, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for

[9] Formerly referred to as a Health Risk Assessment.

				reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported
Health Assessment Offered	AS ABOVE	*Yes/No*	AS ABOVE	AS ABOVE
Plan-Approved Patient-Centered Medical Home Practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Encourage Participation in Other Plan-Designated High Performance Practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Encourage Participation in Weight-Loss Program (Exercise and/or Diet/Nutrition)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Tobacco Cessation Program	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Health Coaching	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Wellness Goals Other than Weight-Loss and Tobacco Cessation (Stress Management, Mental Health)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Confirm Incentives Not Based on Participation or Completion	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Well Child & Adolescent Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Preventive Care (e.g. Cancer Screening, Immunizations)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
OTHER				

In Section II.E below, additional 2012 and 2013 eValue8 Health Plan RFI questions have been selected and licensed for use by the California Health Benefit Exchange. These questions reflect the Exchange's commitment to align purchasing strategies with public and private purchasers, as well as promote Issuer accountability for the Exchange's Guidelines for Qualified Health Plans.

5. MULTI-YEAR CONTRACTING

The Exchange seeks to promote multi-year contracts and provide incentives submitting initial rates at the most competitive position possible, foster rate stability and encourage QHP investments in product design, network development, and quality improvement programs. Solicitation responses that demonstrate an interest and commitment to the long-term success of the Exchange's mission, including proposals for

multi-year contracts are strongly encouraged, particularly those that may propose multi-year contracts that include underserved service areas, premium guarantees or proposed formula caps, and that leverage Issuer efforts to provide better care, improve health, and lower cost.

The Exchange is committed to selecting QHPs to be offered through the Exchange in 2014 with the goal of generally not adding new plans in 2015 and 2016, subject to the Exchange's ongoing review of the quality and value provided by contracted QHP's and its obligation to recertify or decertify QHPs as required by Federal law. The Exchange does not anticipate conducting a full solicitation process in years 2015 and 2016. Eligible Bidders in those years would likely be limited to QHPs selected in 2014 that do not enter into multi-year contracts, service area expansions of QHPs selected for offer in 2014, and Medi-Cal managed care plans. Under limited circumstances, the Exchange may consider the possibility of adding new QHPs in 2015 and 2016 but it is unlikely.

(1) Multi-Year Bid and Cost Proposal: The Exchange prefers to enter into long-term (up to three years) contracts with selected QHP Bidders and will entertain discussion of contract terms and conditions for long term contracts which may include a methodology for premium adjustments in years two and three of Exchange operation (CY 2015 and CY 2016).The Exchange will enter into multi-year contract preference to QHP Bidders offering the best overall value in price, quality and product features, marketing and outreach and other components which drive delivery system reform.

(2) Multi-year Contracts Terms and Conditions: The Exchange envisions negotiation of mutually acceptable terms that will encourage QHPs to make a long-term commitment to providing affordable coverage through the Exchange, promoting improvements in the health of enrollees and improvements in the delivery system and fostering enrollment and retention. The provisions of a multi-year contract are subject to negotiation and the following elements are not prescriptive but are approaches to be considered. Elements of a multi-year contract *may* include the following:

- A formula for second and third year premiums that reflects a shared risk/savings approach to the actual health care costs incurred;
- A cap on Issuer profits for QHPs;
- Mutually agreed upon financial/actuarial review of costs incurred and of the cost trends that would be the basis for adjusting premiums in 2015 and 2016;
- Provisions for the plan to recoup unanticipated first year losses that are not resolved through reinsurance or risk adjustment transfers by being reflected in future years' premium;
- Provisions for the plan to reduce future years' premium to the extent first year's loss ratios are lower than agreed upon;

- Future year premium adjustments will require transparency between the Exchange and the successful QHP Bidder in a multi-year contract. The Exchange and the successful QHP Bidder will agree on which rating regions and which products are subject to the multi-year contract and under what conditions;

- Future year premium rates that are part of a multi-year contract are subject to regulatory review.

The Bidder is interested in submitting multi-year bid(s).

___Yes (explain)

___No

If, yes, describe products and rating regions where Bidder may wish to discuss multi-year contracts and premium guarantees.

If yes, indicate the following:

- Which Exchange the Bidder is interested in proposing multi-year contract(s) (Individual, SHOP or both)

- Which rating region(s) the Bidder is interested in multi-year contract(s)

- What product(s) the Bidder proposes for multi-year contract(s)
- Bidder proposal for terms, conditions, and mechanics for multi-year contracts

At its sole discretion, Exchange staff may determine it is in the best interest of the Exchange to initiate discussions with the Bidder regarding multi-year contracts and premium guarantees. Only those Bidders that meet all QHP certification criteria will be invited to enter into a multi-year contract. QHP Bidders that do not enter into multi-year contracts will be required to participate in annual renewal solicitations conducted for recertification and decertification.

C. TECHNICAL SPECIFICATIONS

1. ADMINISTRATIVE AND ACCOUNT MANAGEMENT SUPPORT

a) ***Provide a summary of your organization's capabilities including how long you have been in the business as an Issuer. Are there any recent or anticipated changes in your corporate structure, such as mergers, acquisitions, new venture capital, management team, location of corporate headquarters or tax domicile, stock issue, etc.? If yes, Bidder must describe.***

b) ***Provide a description of any company initiatives, either current or planned, over the next 18 – 24 months which will impact the delivery of services to Exchange members during the contract period. Examples include system changes or migrations, call center opening/closing, or network re-contracting.***

c) ***Do you routinely subcontract any significant portion of your operations or partner with other companies to provide health plan coverage?***

d) ***General***

(1) Bidder must provide an organizational chart of your California operations, including individual and small group line(s) of business.

(2) Bidder must identify the individual(s) who will have primary responsibility for servicing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary.

- Name
- Title
- Department
- Phone
- Fax
- E-mail

2. MEMBER SERVICES

a) ***Will you modify your customer service center operating hours, staffing requirements, and training criteria to meet Exchange requirements? Check the appropriate box and describe.***

___Yes: expected operating hours are 7am to 7pm

___Yes: staffing requirements - Please provide CSR Ratio to members

___Yes: training criteria

___Yes: languages spoken

___Yes: interface with CalHEERS

___No, the organization can handle the increased volume

___No, not willing to modify operations

b) ***Do you have procedures for when a customer service call is received outside of your business hours for covered benefits? If yes, describe what these procedures would be for the Exchange.***

___Yes

___No

c) ***Do you have procedures for when a customer service call is received outside of your business hours for provider coverage in addition to your Nurse Advice Line (e.g., physician medical group (PMG) care or referrals)? If yes, describe what these procedures would be for the Exchange.***

___Yes

___No

d) ***Do you have staff or online resources that assist Members in making informed decisions? Briefly describe your capabilities.***

	Yes/No	Description
State and federal resources		
Community resources		
Provider referrals		
Member benefit summaries		
Member EOCs		
Member claims status		
Other		

e) ***QHPs will be required to respond to and adhere to the requirements of California Health and Safety Code Section 1368 regardless of which State Health Insurance Regulator regulates the QHP.***

3. OUT OF NETWORK BENEFITS

a) ***For non-network, non-emergency claims (hospital and professional), describe the terms and manner in which you administer out-of-network benefits. Can you administer a "Usual, Customary, and Reasonable" (UCR) method utilizing the nonprofit FAIR Health (www.fairhealth.org) database to determine reimbursement amounts? What percentile do you target for non-network UCR? Can you administer different percentiles? What percent of your in-network contract rates does your standard non-network UCR method reflect?***

Non-Network Claims	Yes/No	Describe
Ability to administer FAIR Health UCR method		
Targeted UCR percentile		%
Ability to administer different percentiles		
Amount as a percentage of network contract value		%

4. SYSTEMS AND DATA REPORTING MANAGEMENT

a) ***Does your organization provide any administrative services that are not performed within the United States? If yes, describe.***

___Yes

___No

b) ***Will the secure online tools provided by your organization for the Exchange program staff and Members be available 99.5 percent of the time, twenty-four (24) hours a day, seven (7) days a week? If no, describe level of guaranteed availability.***

___Yes

___No

c) ***Do you proactively monitor, measure, and maintain the application(s) and associated database(s) to maximize system response time/performance on a regular basis and can your organization report status on a quarterly basis? Describe below.***

___Yes

___No

d) ***Do you provide secure online tools for analysis of utilization and cost trends? Describe below.***

___Yes

___No

Indicate (1) the types of data and reporting available to the Exchange on health management and chronic conditions, and (2) the sources of data used to generate the types of reports available to the Exchange. The Exchange expects plans to help assess and improve health status of their Exchange members using a variety of sources. Check all that apply.

	Report Features	**Sources of Data**
Cost	*Multiple-choice* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 5: Trend comparison of two years data – fixed Jan-Dec annual reporting, 6: All of the above reports integrated into single report, 7: Report available for additional fee, 8: Data/reporting not available	*Multiple-choice* 1: HRAs, 2: Medical Claims Data, 3: Pharmacy Claims Data, 4: Lab Values, 5: Other source - please detail below
Utilization	*Same as above*	*Same as above*
Chronic Condition Prevalence	*Same as above*	*Same as above*

Participant Population stratified by Risk and/or Risk Factors	*Same as above*	*Same as above*
Disease Management (DM) program enrollment	*Same as above*	*Same as above*
Change in compliance among DM enrollees (needed tests, drug adherence)	*Same as above*	*Same as above*
Health status change among DM enrollees	*Same as above*	*Same as above*

5. PROVIDER NETWORK

a) ***Using the Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications, identify the percentage of contracted practitioners who are board certified in your network in 2012.***

	Network
PCPs (including OB/GYNs)	%
Specialists (including allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, ophthalmologists, orthopedic surgeons, and otolaryngologists)	%

b) ***Identify your Centers of Excellence participating facilities. Specifically indicate the locations of each facility and the type of procedures included.***

Type of Procedure	**Facility Name and Locations**

c) ***Describe any contractual agreements with your participating providers that preclude your organization from making contract terms transparent to plan sponsors and Members.***

Contract provisions	**Description**
What is your organization doing to change the provisions of your contracts going forward to make this information accessible?	
List provider groups or facilities for which current contract terms preclude provision of information to plan sponsors	

List provider groups or facilities for which current contract terms preclude provision of information to members	

d) ***Detail your organization's physician contracting strategy to allow and/or require the use of a specialty pharmacy provider to dispense certain biotech medications directly to the physician to be administered in the physician's office. Specify any limitations in your physician contracts that would preclude movement of the reimbursement for specialty medications from the medical to the pharmacy benefit.***

e) ***Identify the hospitals terminated between January 1, 2012 to December 31, 2012, including any hospitals that had a break in maintaining a continuous contract during this period.***

Name of Terminated Hospital	**Terminated by Issuer or Hospital**

f) ***Identify the Independent Practice Associations (IPA) and Medical Groups terminated between January 1, 2012 to December 31, 2012, including any IPAs or Medical Groups that had a break in maintaining a continuous contract during this period.***

Name of Terminated IPA/Medical Group	**Terminated by Issuer or IPA/Medical Group**

g) ***Describe your cost containment and reimbursement strategies currently in place with regard to non-network Providers providing***

services in network hospitals (e.g., anesthesiologists, pathologists, and ER physicians)?

h) ***Describe the steps you take to investigate Member-reported quality of care issues regarding a Provider.***

i) ***Describe your analytical methodology for combining Provider cost and quality metrics and using standard health care statistical techniques such as severity of illness indexing, population health risk adjustment, weighted average, "goodness of fit", etc. Include data source and sample size considerations.***

j) ***Provide sample calculations showing how an individual Provider is ranked relative to its peers for efficiency profiling, your appeals and correction process.***[10]

k) ***Identify who reviews and validates the results of your performance measurements program.***

l) ***Describe your plans for network development in 2014 and 2015. Would you be willing to modify this plan to include Exchange-specific sites?***

___Yes, willing to modify these plans.

___No, not willing to modify these plans.

m) ***Which financial incentives are in place or planned to encourage Members to enhance value by use of lower cost and/or higher quality Providers? (Check all that apply):***

___Financial incentives not used

___Network restricted to just "high performance network" physicians

___Differential deductibles, copayments, and/or insurance contributions

___Differential provider payment schedules, thereby affecting patient contribution

___Richer benefit designs, such as lower out-of-pocket maximums

___Retroactive rewards for using value tier providers (e.g., flex credits, prizes)

___Other (describe)

n) ***What non-financial incentives are used to encourage Members to enhance value by use of lower cost and/or higher quality Providers? (Check all that apply)***

[10] Please include an explanation of how your provider ranking methodology comports with the Patient Charter, which can be accessed at http://healthcaredisclosure.org/docs/files/PatientCharter.pdf.

___Non-financial incentives not used

___Information on provider quality and/or costs made available to members through employer, health plan, or other sources

___Other (describe)

o) ***How have you structured provider networks to leverage mid-level providers and physician extenders as a way to drive cost-efficiency and enhance access? If you have not done so, how might you approach this for the Exchange?***

p) ***What telemedicine capabilities do you have as of 9/30/2012? In your response include the scale and scope of this capability including how it could benefit the Exchange and what capabilities will be in place by January 1, 2014.***

Telemedicine Capability	**Description**
In-house	
Outsourced	
Pharmacy coordination with the PBM	

q) ***Provide a list of the specialties offered via telemedicine.***

r) ***What were the top 10 diagnoses seen via telemedicine in 2011?***

s) ***Describe how you review and certify physicians for telemedicine.***

6. MEDICAL MANAGEMENT SERVICES

a) ***Describe how you incorporate Evidence-Based Medicine, monitor outcomes, and assess best practices for behavioral health. Include a description of your efforts to modify networks and best practices that would meet the specific needs of the Exchange population demographics.***

b) ***What are your managed behavioral health network targets and recent actual results for the information?***

	Target	**Actual**
Bed days/1,000 members		
Professional encounters/1,000 members		

c) ***Describe two Quality Improvement Projects (QIPs) conducted within the last five (5) years. This description shall include but is not limited to, the following information:***

QIP Name/Title:	Start/End Dates:

Problem Addressed:
Targeted Population:
Study Question:
Study Indicator(s):
Barrier Analysis:
Interventions Implemented to Address Identified Barriers:
Baseline Measurement:
Re-Measurement (1):
Re-Measurement (2) (At least two required):
Best Practices Related to Sustained Improvement Achieved (if any):

d) ***Describe those procedures and processes used to compare physician performance with clinical guidelines in order to provide report cards and peer-to-peer feedback.***

Procedure / Process	Yes/No	Description
Internally Developed Guidelines		
External Guidelines		
Other		

e) ***What percentage of eligible members currently accesses the Nurse Advice Line? (Provide numerical categories)***

___0-10%

___11-20%

___21-30%

___>31%

f) ***Indicate the availability of the following health information resources. (Check all that apply)***

___24/7 decision support/health information services

___Self-care books

___Preventive care reminders

___Web-based health information

___Integration with other health care vendors

___Integration with a client's internal wellness program

___Newsletter

___Other (describe)

g) ***Is Nurse Advice Line reporting client-specific or book of business?***

___Client-specific

___Book of business

h) ***Explain how your health plan encourages hospitals and other providers to improve patient safety on an ongoing basis.***

7. HEALTH AND DISEASE MANAGEMENT

a) ***Do you perform the following using Health Assessment ("HA") data?***

	Yes (describe)	No
Personalize/tailor messages on preventive reminders		
Focus on individual's health/lifestyle areas		
Populate a personal health record with the information		
Provide action steps for members to take		
Send a reminder when it is time to take next HA		
Relay data to providers		
Refer to lifestyle management programs (online and telephonic)		
Refer to disease management programs		
Assess/stratify risk using both HA and claims data mining		

b) ***Which of the following are communicated to Members? (Check all that apply):***

___Pharmacy compliance reminders

___Personalized reminders for screenings and immunizations

___Plan monitors whether member has received indicated screenings and immunizations and can provide aggregated reports of the percentage of members that have received these.

___None of the above

c) ***If preventive care notification occurs, indicate the following:***

___Reminders are age-sex appropriate

___Reminders are made via e-mail

___Reminder letters are sent

___Reminder telephone calls are made

8. INTEGRATED HEALTHCARE MODEL (IHM)

The Exchange is interested in how Bidders plan to address components of an Integrated Healthcare Model:

An integrated model of health care delivery is one in which there is organizational/operational/policy infrastructure addressing patient care across the continuum of care, population management and improvements in care delivery, IT infrastructure to support care delivery, adherence to Evidence Based Medicine (EBM) behaviors from all providers of care, and financial risk sharing incentives for the health plan, hospital, and medical group that drive continuous improvement in cost, quality, and service.

a) *From an organizational/operational/policy perspective, Bidder must indicate if its delivery model addresses the following, providing descriptions where applicable:*

Attribute	Description
Describe your use of clinical committees to establish practice pathways and guidelines.	
Describe your use of national sources for identification of EBM practice guidelines (list all that apply, e.g., AHRQ, Milliman guidelines).	
Describe your processes in place to address EBM guidelines where national or community guidelines do not exist.	
Describe your procedures to track physician performance practices relative to clinical guidelines and provide report cards and peer-to-peer feedback.	

Attribute	Description
Describe any requirements you may have for your contracted hospitals to report performance information based on the National Quality Forum consensus measures. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69376	
Describe your procedures to provide continuity of care across the care continuum in a Patient-Centered Medical Home (PCMH) model	
Describe your processes to coordinate care management in the following areas:	
a. Pre- and post-discharge planning	
b. Transitional care	
c. Ensuring patient is aware of post discharge follow-up	
d. Ensuring appropriate handoff to PCP and/or specialist	
e. Short term, i.e. < 6 weeks	
f. Long Term/Catastrophic	
g. End of life	

b) ***Describe your measurement strategy for the following areas:***

Strategy	Description
Describe your policies in place to address population health management across covered Members.	
Describe your ability to track Exchange-specific IHM metrics supporting risk-sharing arrangements.	
Describe your processes, if any, to track and monitor clinical and financial performance measurement related to the Integrated Healthcare Association (IHA).	
Describe your ability to track and monitor Exchange-specific data in the following areas:	

a. Member satisfaction	
b. Cost and utilization management (e.g., admission rates, complication rates, readmissions)	
c. Clinical outcome quality	

c) For your non-IHM hospitals and physicians, describe how you support the following:

Attribute	Description
Member EHR including Rx, Lab, radiology, IP, OP, physician encounters, picture archiving capability, clinical data repository, and health information exchange	
Computerized Provider Order Entry (CPOE)	
Interoperability of Member PHR with other data sources, e.g., coaching, wellness exams, current prescriptions and related services	
E-prescribing support for Surescripts Rx hub	
Disease registries	
Real-time access to patient EHRs for all clinical providers across care continuum	
Algorithms that address gaps in care	
Physician messaging with Member-specific triggers around gaps	
Ability to identify overuse, under-utilization, and misuse of services	
Access to data by Providers and Members across the continuum of care (e.g., Physicians, Hospitalists, Case Managers, etc.)	
Decision support for Member and Physician interaction in care management	
EHR infrastructure provided either by the Plan or the Providers	
Homegrown EHR infrastructure / platform	
Level of EHR integration	

9. INNOVATIONS

a) ***Other than what is mentioned elsewhere in this proposal, describe up to three examples of your organization's successful innovations to improve healthcare quality and reduce costs. Discuss scope of the innovation, targeted population, goals, outcomes (quality and cost), and scalability and/or plans for dissemination.***

b) ***Describe your institutional capacity to plan, implement, and evaluate future healthcare quality and cost innovations for Exchange Members.***

10. IMPLEMENTATION PERFORMANCE

a) ***Will an implementation manager and support team (not part of the regular account management team) be assigned to lead and coordinate the implementation activities with the Exchange? If yes, specify the name and title of the individual.***

b) ***Indicate the ideal notification date to achieve a successful implementation for the Exchange effective date of January 1, 2014.***

c) ***Should your organization's QHPs be certified by the Exchange explain how you anticipate accommodating the sizeable additional membership effective January 1, 2014 (discuss anticipated hiring needs, staff reorganization, etc.):***

- Member Services
- Claims
- Account Management Clinical staff
- Disease Management staff
- Implementation
- Financial / Administrative Information Technology Other (describe)

d) ***Indicate your procedures for handling the following during the transition period. Check all that apply:***

___Request transfer from prior plan and utilize information to continue plan/benefit accumulators

___Load claim history from prior plan, if any.

___Services that have been pre-certified but not completed as of the effective date must also be pre-certified by new plan.

___Services that have been pre-certified but not completed as of the effective date will be honored and payable by new plan.

___Will provide pre-enrollment materials to participants within standard fees.

___Will make customer service line available to participants prior to the effective date.

___Provide an attachment describing your network transition of care provisions for patients that are currently receiving care for services at practitioners that are not in your network.

___Provide member communications regarding change in plans.

e) ***Provide a detailed implementation project plan and schedule targeting a January 1, 2014 effective date.***

11. FRAUD, WASTE, AND ABUSE DETECTION/PREVENTION SERVICES

The Exchange is committed to working with its QHPs to establish common efforts to minimize fraud, waste and abuse.

Fraud - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste - Waste is the intentional or unintentional, thoughtless or careless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse – Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse can also occur with excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Abuse can occur in financial or non-financial settings.

a) Describe the processes used in addressing fraud, waste, and abuse for the following:

Process	**Description**
Determining what is investigated • Specific event triggers • Overall surveillance, audits and scans	

Process	Description
Method for determining whether fraud, waste, and abuse has occurred	
Follow-up and corrective measures	
Recovery and remittance of funds	

b) Describe your approach to the following:

Approach	Description
Controls in place to confirm non-contracted Providers who file Claims for amounts above a defined expected threshold of the reasonable and customary amount for that procedure and area.	
Use of the Healthcare Integrity and Protection Data Bank (HIPDB) as part of the credentialing and re-credentialing process for contracted Providers.	
Controls in place to monitor referrals of Plan Members to any health care facility or business entity in which the Provider may have full or partial ownership or own shares.	
Controls in place to confirm enrollment and disenrollment actions are accurately and promptly executed.	
Other	

c) Provide a brief description of your fraud detection policies (i.e., fraud as it relates to Providers and Plan Members).

Providers	
Plan Members	

d) Provide a sample copy of your fraud, waste, and abuse report.

☐ Sample provided.
☐ Sample not provided.

e) Indicate how frequently internal audits are performed for each of the following areas.

	Claims Admin.	Customer Service	Network Contracting	Eligibility & Enrollment	Utilization Management	Billing
Daily						
Weekly						
Monthly						
Quarterly						
Other (specify)						

f) Overall, what percent of Claims are subject to internal audit?

%

g) Indicate if external audits were conducted for Claims administration for your entire book of business for the last two (2) full calendar years.

	Audit Conducted	Audit Not Conducted
Most recent year		
Prior year		

h) Indicate the types of Claims and Providers that you typically review for possible fraudulent activity. Check all that apply.

- ☐ Hospitals
- ☐ Physicians
- ☐ Skilled nursing
- ☐ Chiropractic
- ☐ Podiatry
- ☐ Behavioral Health
- ☐ Alternative medical care
- ☐ Durable medical equipment Providers
- ☐ Other service Providers

i) Describe the different approaches you take to monitor these types of Providers.

j) Specify your system for flagging unusual patterns of care. Check all that apply:

☐ Identified at time of Claim submission

☐	Data mining
☐	Plan Member referrals
☐	Other – Specify

k) What was your organization's recovery success rate and dollars recovered for fraudulent Claims?

2011	%	$
2010	%	$

l) Describe the controls in place to ensure the California Health Benefit Exchange assessment revenue is accurately and timely paid.

m) Describe your revenue recovery process to recoup erroneously paid claims.

D. ADDITIONAL QUESTIONS AND/OR REQUIREMENTS

1. AGENT RELATIONS, FEES, AND COMMISSIONS[11]

a) ***Do you currently provide agent-oriented marketing materials for the individual and small business market?***

	Yes	No
Individual		
Small Group		

If yes, please include sample materials or your broker kit as an attachment labeled "Broker Kit".

b) ***What initiatives is your organization undertaking in order to partner more effectively with the small business and agent communities?***

c) ***What criteria do you use to credential agents to sell Individual and Small Group products?***

d) ***Does your health plan cultivate relationships with general agents? If so, please list the general agents with whom you contract.***

[11] **For SHOP Exchange Bidders only.**

e) ***Describe your health plan agent compensation schedule for your individual and small group business.***

f) ***Describe any bonus program your company currently has in place for additional agent compensation. This may include cash bonuses or in-kind compensation programs.***

g) ***In 2011 or 2012, did your health plan place ads in agent--related trade publications?***

___Yes

___No

h) ***Bidder must list the trade publications you placed ads in.***

2. MARKETING AND OUTREACH ACTIVITIES

The Exchange looks forward to working closely with QHPs to maximize enrollment in the Exchange, which may take the form of coordinating marketing efforts and developing promotion opportunities through co-branding. QHPs acknowledge that the Exchange will establish specific requirements regarding a QHP's use of the Exchange brand name, logo, and taglines.

In the questions that follow, Bidders must provide detailed information pertaining to the Bidder's plans for marketing and advertising for the individual and small group market. Where specific materials are requested, please be sure to label the attachments clearly.

a) ***General***

(1) Bidder must provide an organizational chart of your individual and small group sales and marketing department.

(2) Bidder must identify the individual(s) with primary responsibility for sales and marketing of the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information:

- Name
- Title
- Department
- Phone
- Fax
- E-mail

(3) Bidder must provide a copy of your most recent summary brochure as an attachment to the response to this solicitation labeled "Summary Brochure".

b) *Financial*

(1) Bidder must indicate estimated total planned expenditures/allocations (separately detailing estimates for payments to agents from other marketing and outreach) for Exchange-related marketing and advertising functions during the years 2013 and 2014:

Total Estimated Allocation

2013 Marketing and Advertising $_____

2013 Payments to Agents $_____

2014 Marketing and Advertising $_____

2014 Payments to Agents $_____

(2) Bidder must indicate estimated total expenditures/allocations for Individual and Small Group related marketing and advertising functions during the most recent Calendar Year/Fiscal Year. Using the table below, Bidder must provide a detailed picture of how this individual and small group funding commitment was applied. Indicate N/A if the Bidder did not market Individual or Small Group products in the most recent period.

Repeat Table for Individual and Small Group or add to Attachment workbook.

Marketing Results	Total Cost	Total Sales	Cost per Sale
Billboards			
Newspapers			
Trade Publications			
Magazines			
Radio			
Television			
Internet/Online			
Referrals			
Broker Seminars			
Incoming Unsolicited Calls			
Telemarketing			
Mailers/Direct Mail			
Direct Sales to Businesses			
Other (specify)			

c) *Cooperation with the Exchange*

(1) Bidder must describe its plan to cooperate with Exchange marketing and outreach efforts, including internal and external training, collateral materials and other efforts. Please note that it will be a contractual requirement to place the Exchange's brand name, logo and tagline on all billing statements and customer communications. The location and size will be discussed with each Issuer. In addition, the Exchange will retain the right to communicate with Exchange customers and members.

3. OPERATIONAL REPORTING REQUIREMENTS

Issuers must maintain data interfaces with the Exchange and allow the Exchange to monitor issuer operational performance. For example, QHPs will be required to provide provider network data to allow the Exchange to create a centralized provider directory. The Exchange will issue required provider data elements to successful bidders. Further, QHPs must build data interfaces with the Exchange's eligibility and enrollment systems and report on transactions.

4. OTHER REPORTING REQUIREMENTS: NOT COVERED ELSEWHERE

The following is a list of other reporting measures under consideration as part of Exchange monitoring. These metrics may also be considered as potential performance guarantees or risk based payments. Bidder must indicate if you

collect these metrics and the ability to collect these metrics on the Exchange population beginning as of January 1, 2014.

1.	**OPERATIONS (Exchange-Specific)**	
2.	***QUALITY (Issuer Book of Business)***	
3.	**PATIENT EXPERIENCE (Exchange-Specific or Book of Business)**	

	Performance Measure	*Collect Yes/No*	*Exchange Yes/No*
	OPERATIONS (Exchange-Specific)		
1.	Claim Turnaround Time: Percentage of clean claims processed within 30 calendar days of receipt		
2.	Financial Accuracy: Percentage of claim dollars paid accurately		
3.	Procedural Accuracy: Percentage of claims without any financial error		
4.	Percentage of callers who reach a live voice within 30 seconds.		
5.	Percentage of callers whose issue is resolved on the initial call		
6	Quarterly group-specific utilization and cost data reports delivered timely 4/4 quarters		
7	Bi-annual group-specific quality and disease management program reports delivered timely 2/2		
8	Provide consumer engagement reports (participation in wellness programs, online tools, HRA completion)		
9	Web site availability 99.99% (no more than 1 hour down time)		
10	Monthly report on classification of member service issues (phone, email and written correspondence) and resolution rate delivered timely 12/12 months		
11	Enrollment data processed within 5 business days of provision by Exchange (no more than 2 missed cycles)		
	QUALITY (Issuer Book of Business)		
12	Chlamydia screening (all age categories)		
13	Appropriate treatment for children with upper respiratory infection		
14	Mammography screening		
15	Diabetes care – blood sugar (HbA1c) testing		
16	Glycemic control rate (poor control)		
17	Diabetic eye exam rate		

	Performance Measure	*Collect Yes/No*	*Exchange Yes/No*
18	Diabetic lipid profile performed		
19	Diabetic lipid control rate		
20	Diabetic nephropathy monitoring rate		
21	Appropriate medications for people with asthma (18-56)		
22	Childhood immunizations (Combination 3)		
23	Controlling High Blood Pressure		
24	Persistence of beta blocker use after heart attack		
25	Follow-up after hospitalization for mental illness – patients receiving outpatient follow-up care within 7 days of discharge		
26	Follow-up after hospitalization for mental illness – patients receiving outpatient follow-up care within 30 days of discharge		
27	Anti-depression medication management – effective acute phase treatment		
28	Anti-depression medication management - effective continuation phase treatment		
29	Low back imaging		
30	Advice to quit smoking (CAHPS)		
31	Aspirin use among members with cardiovascular risk (CAHPS)		
	PATIENT EXPERIENCE (Exchange-Specific or Book of Business)		
32	Overall satisfaction with health plan		
33	Access to specialty care		
34	Ease of getting appointment for care you thought you needed		
35	Customer service composite		
36	Health information in written materials clear and easy to read		

E. eVALUE8 REQUEST FOR INFORMATION

For purposes of this section, Plan is used in place of Bidder, to be consistent with the terminology used in eValue8. Please note that Bidders who have already completed eValue8 for 2012 may import information that has been previously submitted. Selected sections of 2013 eValue8 are presented in this solicitation with the original numbering system used in eValue8 listed in parenthesis for ease of reference. Please note that the gaps in the numeric sequencing of the eValue8 RFI questions represent questions from the full eValue8 Health Plan RFI questionnaire that will be skipped for the Exchange RFP to reduce reporting burden. A document with the full mapping of the subset of eValue8 questions used in this Solicitation will be available online.

Bidders must answer all questions for current California - based business. If Issuer provides services or reports data on a national or regional basis and cannot provide California specific responses, the response must be identified as a response based on national or regional operations. If the Issuer offers products in the Individual and Small Group market and can separately report those results, Bidder must indicate that in your response.

1 Plan Profile

1.1 Instructions

1.1.1 You may rely on the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

1.1.2 All attachments to this module must be labeled as "Profile #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Profile 1a, Profile 1b, etc.

1.1.3 All responses for the 2013 Request for Information (RFI) must reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. The PPO VERSION question always follows the HMO question. Note in questions where HEDIS[12] or CAHPS [13]data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For Issuers that have submitted results to Quality Compass the HEDIS and CAHPS, the responses have been auto-populated but information should be reviewed. To activate the appropriate HMO and/or PPO VERSION questions in this template, please answer the question below in 1.1.5.

[12] Healthcare Effectiveness and Information Set (HEDIS)
[13] Consumer Assessment of Healthcare Providers and Systems (CAHPS)

1.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

1.1.5 Plan is responding for the following products

Multi, Checkboxes.
1: HMO/POS,
2: PPO

1.1.6 Additional information that Bidder wishes to provide that is not addressed elsewhere within each section can be provided at the end of the section.

1.2 Contact and Organization Information

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 1.8.

1.2.1 Provide the information below for the local office of the Plan for which this RFI response is being submitted.

1.2.2 (1.2.3) Complete the table below for the individuals responsible for the market for which this RFI response is being submitted.

	Contact Name	**Title**	**Phone (include extension)**	**Fax**	**E-mail**
Primary Contact (for RFI)	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Secondary Contact	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*	*Unlimited.*
Other	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.	*Unlimited.* N/A OK.

1.2.3 (1.2.4) Tax Status

Single, Pull-down list.
1: Profit,
2: Non-Profit

1.2.4 (1.2.5) Did ownership change in 2012 or is a change being considered in 2013?

Single, Pull-down list.
1: Yes (describe):,
2: No

1.3 Enrollment and Scope of RFI Response

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 1.8 (1.10).

1.3.1 If plan is responding for HMO and/or PPO products and has not made a selection in 1.1.5 – please do so before proceeding so that the appropriate questions are active.

1.3.2 For plans that operate locally but not statewide, identify the Plan membership in each of the products specified below within the response market as of 9/30/12. Enter 0 if

product not offered. Please provide an answer for all products the Plan offers. Please copy this response into the following questions, 1.3.3 and 1.3.4.

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Fully-insured, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Other (describe in "Other Information")	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Total	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0

1.3.3 Identify the Plan membership in each of the products specified below for the state of California as of 9/30/12. Enter 0 if product not offered. Please provide an answer for all products the Plan offers.

Plans that operate in ONLY one market should copy their response from previous question to this question as numbers in 1.3.3 are used to auto-populate some responses in consumer module (see Section 2 Consumer Engagement).

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Fully-insured, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Other (describe in "Other Information")	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Total	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0

1.3.4 (1.3.3) Identify the Plan membership in each of the products specified below nationally as of 9/30/12. Enter 0 if product not offered. Please provide an answer for all products the Plan offers.

	Total Commercial HMO/POS	Total Commercial PPO	All other Commercial products	Total Medicare Members	Total Medicaid Members
Self-funded, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Fully-insured, Plan administered	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Other (describe in "Other Information")	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*	*Decimal.*
Total	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0	*For comparison.* 0

1.3.5 (1.3.4) Please provide a signed Attestation of Accuracy form. A template version of the document is attached and can be downloaded from the documents manager. Please label as Plan Profile 1**.**

Single, Radio group.
1: Yes, a signed version of the attestation is attached,
2: Not provided

The Attestation of Accuracy form can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/Revised%20QHP%20Attestation_v3.pdf

1.4 Services and Compliance Reviews

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 1.8.

1.4.1 Please provide the NCQA accreditation status and expiration date of the accreditation achieved for the HMO product identified in this response. Indicate all that apply. For the URAC Accreditation option, please enter each expiration date in the detail box if the Plan has earned multiple URAC accreditations.

This question needs to be answered in entirety by the Plan. Note that plan response about NCQA PHQ Certification should be consistent with plan response in question #3.4.1 in module 3 on the Consumer Disclosure project where PHQ is a response option.

	Answer	Expiration date MM/DD/YYYY	Programs Reviewed
NCQA MCO	*Single, Pull-down list.* 1: Excellent, 2: Commendable, 3: Accredited, 4: NCQA not used or product not eligible	*To the day.* From Dec 31, 1971 to Jan 01, 2022.	
NCQA Wellness & Health Promotion Accreditation	*Single, Radio group.* 1: Accredited and Reporting Measures to NCQA, 2: Accredited and NOT reporting measures, 3: Did not participate	*To the day.* From Dec 31, 1970 to Feb 14, 2014.	*Unlimited.*
NCQA Disease Management – Accreditation	*Multi, Checkboxes.* 1: Patient and practitioner oriented, 2: Patient oriented, 3: Plan Oriented, 4: NCQA not used	*To the day.* From Dec 31, 1970 to Feb 14, 2014.	*Unlimited.*
NCQA Disease Management – Certification	*Multi, Checkboxes.* 1: Program Design, 2: Systems, 3: Contact, 4: NCQA not used	*To the day.* From Dec 31, 1970 to Feb 14, 2014.	*Unlimited.*
NCQA PHQ Certification	*Single, Pull-down list.* 1: Certified, 2: No PHQ Certification	*To the day.* From Dec 31, 1969 to Feb 14, 2014.	
URAC Accreditations	*Multi, Checkboxes - optional.* 1: URAC not used		
URAC Accreditations - Health Plan	*Single, Radio group.* 1: URAC Accredited, 2: Not URAC Accredited	*To the day.* From Dec 31, 1970 to Jan 01, 2021.	
URAC Accreditation - Comprehensive Wellness	AS ABOVE	AS ABOVE	
URAC Accreditations - Disease Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Health Utilization Management	AS ABOVE	AS ABOVE	
URAC Accreditations - Case Management	AS ABOVE	AS ABOVE	

1.4.2 PPO VERSION OF ABOVE

1.5 Provider Management and Payment Reform

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 1.8.

The following questions have been added to update and simplify existing questions regarding Provider Measurement and Rewards: 1.5.3, 3.5.1, 3.5.4, 3.5.7, 3.5.8, 3.7.1, 3.7.2, 3.7.6. They were developed in collaboration with Catalyst for Payment Reform (CPR).

CPR has received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses in questions. Information on the National Scorecard and Compendium can be found at http://catalyzepaymentreform.org/National_Scorecard.html

The CPR California Payment Reform Scorecard will report an aggregate result, e.g. "In 2012, x% of total in-network dollars were paid out as payment reform." - No plans will be identified.

The description of the payment reform programs in 3.5.1 and 3.7.1 will be reported publicly as part of CPR's Compendium for Payment Reform. Plans can opt out of having their program information reported publicly.

1.5.1 Plans are expected to manage their network and contract renewals to ensure members are held harmless in instances where there are no negotiated contracts with in-network hospital-based physicians (anesthesia, pathology, radiology, ER). The Exchange recognizes the dynamics of negotiation and welcomes ways in which they might be helpful to motivate hospitals to require hospital-based specialists to provide agreed upon fees for each plan with which they have contracts.

If the Plan has circumstances where there is no agreed upon fees agreement with hospital-based specialists, indicate how claims are treated by HMO.

HMO Response	Treatment of claims if no discounted agreement	Other (limit 100 words)
Self-funded plans	*Multi, Checkboxes.* 1: Considered in-network, 2: Considered out-of-network, member incurs higher cost-share, 3: All Plan hospital-based specialists have discounted agreement, 4: Employer option to decide, 5. Paid at Usual and Customary based on Fair Health 6: Other (describe in next column), 7: Unknown	*100 words.*
Fully-insured plans	AS ABOVE	

1.5.2 PPO VERSION OF ABOVE

1.5.3 (1.5.6) On behalf of Purchasers and to reduce response burden, NBCH and the Catalyst for Payment Reform (CPR) are collaborating on a set of questions to collect and report plan responses with respect to payment reform. This set of questions will be flagged as CPR. A subset of questions (1.5.3, 3.5.1, 3.5.4, 3.5.7, 3.5.8, 3.7.1, 3.7.2, 3.7.6) will replace other payment reform questions that were posed in eValue8 2012. The goal of this new set of questions on payment

reform is to inform and track the nation's progress on payment reform initiatives. CPR has received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses to questions. Information on the National Scorecard and Compendium can be found at http://catalyzepaymentreform.org/National_Scorecard.html. Results of the responses for the National Scorecard will be displayed in the aggregate (i.e., health plans will not be identified and there will be no plan-to-plan comparison).

The goal of this question is to establish the context as well as establish the denominators for other questions in module 3. Potential examples of results/metrics reported on the scorecard will be *"Dollars spent on commercial market represent x% out of all dollars paid"; "Dollars paid to all in-network providers for all commercial lives represent y% of all dollars paid"; "Dollars paid through reference pricing with quality components represent z% of all in-network commercial dollars paid"*

NOTE: This question asks about total dollars ($) paid for PUBLIC as well as PRIVATE programs in calendar year (CY) 2012. If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2012, Plans may elect to report on the most recent 12 months with sufficient information and note the time period in the detail box below. If this election is made, ALL answers on CPR payment questions (1.5.3, 3.4.2, 3.5.4, 3.5.7, 3.5.8 3.7.2 , 3.7.5 and 3.7.6) for CY 2012 should reflect the adjusted reporting period.

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial members, not including prescription drug costs.

- Commercial includes both self-funded and fully-insured business.

- Some of the questions, such as "Provide the total in-network dollars paid to providers for commercial members CY 2012," apply to multiple metrics and will inform multiple denominators. Accordingly, this question is only posed once but the answer will be used to calculate all relevant metrics.

	Total $ Paid in Calendar Year (CY) 2012 or the most current 12 months with sufficient dollar information	Calculated percent Numerator = # in specific row Denominator for rows 1 to 5= Total in Row 6	Description of metric	Row Number
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for FULLY-INSURED commercial members	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Health Plan Dollars - Fully-Insured Commercial In-Network:** Total in-network dollars paid to providers for fully-insured commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	1
Total IN-NETWORK dollars paid to ALL providers (including hospitals) for SELF-INSURED commercial	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Health Plan Dollars - Self-Funded Commercial In-Network:** Total in-network dollars paid to providers for self-funded commercial members as a percent of total dollars paid to ALL providers for ALL lines of	2

members			business	
Total OUT-OF-NETWORK dollars paid to ALL providers (including hospitals) for ALL (fully-insured and self-insured) commercial members	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Health Plan Dollars - Commercial Out-of-Network:** Total out-of-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business	3
Total dollars paid to ALL providers for public programs (involving non-commercial members)	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Health Plan Dollars - Public Programs:** Total dollars paid to providers for public programs as a percent of total dollars paid to ALL providers for ALL lines of business	4
Calculated: Total IN-NETWORK dollars paid to ALL providers (including hospitals) for ALL commercial members.(sum of rows 1 and 2)	*For comparison.* 0	*For comparison.* Unknown	**Health Plan Dollars - Total Commercial In-Network:** Total in-network dollars paid to providers for commercial members as a percent of total dollars paid to ALL providers for ALL lines of business. This is the denominator used for autocalc in rows 7 & 8	5
Calculated: Total dollars paid to all providers for all lines of business (sum of rows 3, 4 and 5)	*For comparison.* 0	*For comparison.* Unknown	Denominator for rows 1 to 5	6
Provide the total IN-NETWORK COMMERCIAL dollars paid to ALL providers (including hospitals) through reference pricing without quality components	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Steps to Payment Reform - Reference Pricing**: Total dollars paid through reference pricing as percent of total commercial in-network dollars	7
Provide the total IN-NETWORK COMMERCIAL dollars paid to ALL providers (including hospitals) through reference pricing with quality components (e.g. Value Pricing). More information about reference and value pricing can be found at http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf	*Decimal.* N/A OK. From 0 to 100000000.	*For comparison.* Unknown	**Steps to Payment Reform - Value-Based Pricing**: Total dollars paid through reference pricing with quality components as percent of total commercial in-network dollars	8

Detail Box: Note the 12 month time period used by respondent for all payment reform questions if time period is NOT the requested CY 2012

1.6. Purchaser Support

1.6.1 For the book of business represented by this RFI response and supported by the attachment(s) labeled as Profile 2 in question below, indicate (1) the types of data and reporting available to employers and/or their designated vendors on health management and chronic conditions, and (2) the sources of data used to generate the types of reports available to Employers. Purchasers expect plans to help assess and improve health status of their Participants using a variety of sources. Check all that apply.

	Report Features for Fully Insured Lives/Plan	**Report Features for Self Insured Lives/Plan**	**Sources of Data**
Chronic Condition Prevalence	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 5: Trend comparison of two years data – fixed Jan-Dec annual reporting, 6: All of the above reports integrated into single report, 7: Report available for additional fee, 8: Data/reporting not available	*Multi, Checkboxes.* 1: Group-specific results reported, 2: Comparison targets/benchmarks of book-of-business, 3: Comparison benchmarks of similarly sized groups, 4: Trend comparison of two years data – rolling time period, 5: Trend comparison of two years data – fixed Jan-Dec annual reporting, 6: All of the above reports integrated into single report, 7: Report available for additional fee, 8: Data/reporting not available	*Multi, Checkboxes.* 1: HRAs, 2: Medical Claims Data, 3: Pharmacy Claims Data, 4: Lab Values, 5: Other source - please detail below
Participant Population stratified by Risk and/or Risk Factors	AS ABOVE	AS ABOVE	AS ABOVE
Disease Management (DM) program enrollment	AS ABOVE	AS ABOVE	AS ABOVE
Change in compliance among DM enrollees (needed tests, drug adherence)	AS ABOVE	AS ABOVE	AS ABOVE
Health status change among DM enrollees	AS ABOVE	AS ABOVE	AS ABOVE

1.6.2 Attachments are needed to support plan responses to the question above. Provide as Profile 2 blinded samples of standard purchaser report(s) for chronic condition prevalence OR management, population risk stratification, and changes in compliance OR health status (attachments needed for 3 of the 5 rows depending on plan response). FOR RESPONSES SELECTED in question ABOVE, Provide LABELED samples of reports for (1) group-specific results, (2) Comparison targets/benchmarks of book-of-business OR Comparison benchmarks of similarly sized groups, (3) Trend comparison of two years data - rolling time period, and (4) Trend comparison of two years data - fixed Jan-Dec annual reporting ONLY IF PLAN DID NOT SELECT AND PROVIDE SUPPORT FOR "Trend comparison of two years data - rolling time period"

For example if plan responds that they can provide group specific results (response option 1) with comparison benchmarks of similarly sized groups are available with trend comparison data of two years rolling and fixed for parameters in first 3 rows (chronic disease prevalence, Participant Population stratified by Risk and/or Risk Factors and Disease Management (DM) program enrollment) – the following samples must be attached:

1) Report showing participant population stratified by risk or risk factors for the specified group compared to a different similarly sized group over a rolling time frame of 24 months

2) Report showing either prevalence of chronic disease OR DM program enrollment factors for the specified group compared to a different similarly sized group over a rolling time frame of 24 months

IF REPORT FEATURE OPTION 6 "All of the above reports integrated into single report" IS SELECTED, please provide a blinded sample of such an integrated report with the sections CLEARLY LABELED

Single, Radio group.
1: Profile 2 is provided,
2: Not provided

1.6.3 Indicate the beneficiary communication and outreach support offered to the Plan's Purchaser customers. Address communication about the existence of member support tools and how to access and use them, note the communication that takes place within each program.

Examples of on-site services include member enrollment support or product demonstrations at participant health fairs or open enrollment meetings. Check all that apply. "Pharmaceutical decision support information" is meant to indicate ongoing member support services such as online information (e.g., drug dictionaries, generic equivalents, etc.), general information mailings or targeted member mailings, (e.g., targeted mailings to members who may be taking a brand drug that is coming off-patent identifying available alternatives).

Program area	Type of support (for fully insured lives/plan)	Type of support (for lives/plan)
Prevention/health/wellness materials	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available	*Multi, Checkboxes.* 1: On-site support with fee, 2: On-site support at no charge, 3: Customizable company logo placement in written communications with fee, 4: Customizable company logo placement in written communications at no charge, 5: Customizable text in written communications with fee, 6: Customizable text in written communications at no charge, 7: Standard written communications, 8: Support not available
Prevention/health/wellness biometric testing	AS ABOVE	AS ABOVE
Disease management program information	AS ABOVE	AS ABOVE
Practitioner/Hospital selection/comparison information	AS ABOVE	AS ABOVE
Pharmaceutical decision support information	AS ABOVE	AS ABOVE
Treatment option decision support information	AS ABOVE	AS ABOVE
Personal health record information	AS ABOVE	AS ABOVE
Price comparison information	AS ABOVE	AS ABOVE

1.7 (1.8) Racial, Cultural and Language Competency

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 1.8.

1.7.1 (1.8.1) Identify the sources of information gathered about commercial members' race/ethnicity, primary language and interpreter need. The response for Enrollment Form pertains only to information reported directly by members (or as passed on from employers about specific members).

For the last column, as this is not a region/market specific question, please provide the statewide % for members captured across all markets.

	Data collected from all new enrollees (specify date started - MM/DD/YYYY)	**Data collected from previously enrolled members (specify method)**	**members captured as percent of total commercial population (statewide)**
Race/ethnicity	*To the day.* N/A OK.	*Multi, Checkboxes.* 1: Enrollment form, 2: Health Assessment, 3: Information requested upon Website registration, 4: Inquiry upon call to Customer Service, 5: Inquiry upon call to Clinical Service line, 6: Imputed method such as zip code or surname analysis, 7: Other (specify in detail box below. 200 word limit), 8: Data not collected	*Percent.*
Primary language	AS ABOVE	AS ABOVE	AS ABOVE
Interpreter need	AS ABOVE	AS ABOVE	AS ABOVE

1.7.2 (1.8.2) Provide an estimate of the percent of network physicians, office staff and Plan personnel in this market for which the plan has identified race/ethnicity, and a language spoken other than English?

	Physicians in this market	**Physician office staff in this market**	**Plan staff in this market**
Race/ethnicity	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.
Languages spoken	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.	*Percent.* From 0 to 100.

1.7.3 (1.8.3) Indicate how racial, ethnic, and/or language data is used? Check all that apply.

Multi, Checkboxes.

1: Assess adequacy of language assistance to meet members' needs,
2: Calculate HEDIS or other clinical quality performance measures by race, ethnicity, or language,
3: Calculate CAHPS or other measures of member experience by race, ethnicity, or language,
4: Identify areas for quality improvement/disease management/ health education/promotion,
5: Share with enrollees to enable them to select concordant clinicians,
6: Share with provider network to assist them in providing language assistance and culturally competent care,
7: Set benchmarks (e.g., target goals for reducing measured disparities in preventive or diagnostic care),

8: Determine provider performance bonuses and/or contract renewals (e.g. based on evidence of disparity outlier status),
9: Analyze disenrollment patterns,
10: Develop disease management or other outreach programs that are culturally sensitive,
11: Racial, ethnic, language data is not used

1.7.4 (1.8.4) How does the Plan support the needs of members with limited English proficiency? Check all that apply.

Multi, Checkboxes.

1: Test or verify proficiency of bilingual non-clinical Plan staff,
2: Test or verify proficiency of bilingual clinicians,
3: Certify professional interpreters,
4: Test or verify proficiency of interpreters to understand and communicate medical terminology,
5: Train practitioners to work with interpreters,
6: Distribute translated lists of bilingual clinicians to members,
7: Distribute a list of interpreter services and distribute to provider network,
8: Pay for in-person interpreter services used by provider network,
9: Pay for telephone interpreter services used by provider network,
10: Pay for in-person interpreter services for non-clinical member interactions with plans,
11: Negotiate discounts on interpreter services for provider network,
12: Train ad-hoc interpreters,
13: Provide or pay for foreign language training,
14: Formulate and publicize policy on using minor children, other family, or friends as interpreters,
15: Notify members of their right to free language assistance,
16: Notify provider network of members' right to free language assistance,
17: Develop written policy on providing language services to members with limited English proficiency,
18: Provide patient education materials in different languages. Percent in a language other than English: [Percent] Media: [Multi, Checkboxes],
19: Other (describe in detail box below):,
20: Plan does not implement activities to support needs of members with limited English proficiency

1.7.5 (1.8.5) Indicate which of the following activities the Plan undertook in 2012 to assure that culturally competent health care is delivered. This shall be evaluated with regard to language, culture or ethnicity, sexual orientation, and other factors. Check all that apply.

Multi, Checkboxes.

1: Assess cultural competency needs of members,
2: Conduct an organizational cultural competence assessment of the Plan,
3: Conduct a cultural competence assessment of physician offices,
4: Employ a cultural and linguistic services coordinator or specialists,
5: Seek advice from a Community Advisory Board or otherwise obtain input from community-based organizations,
6: Collaborate with statewide or Statewide medical association groups focused on cultural competency issues,
7: Tailor health promotion to particular cultural groups,
8: Tailor disease management activities to particular cultural groups,
9: Public reporting of cultural competence programs, staffing and resources,
10: Sponsor cultural competence training for Plan staff,
11: Sponsor cultural competence training for physician offices,
12: Other (describe in detail box below):,
13: No activities in year of this response

1.7.6 (1.8.6) Has the Plan evaluated or measured the impact of any language assistance activities? If yes, describe the detail box below the evaluation results of the specific disparities that were reduced and provide a description of the intervention if applicable.

Yes/No.

1.8 (1.10) Other Information

1.8.1 (1.10.1) If the Plan would like to provide additional information about Plan Profile that was not reflected in this section, please attach as Profile 4.

2 Consumer Engagement

2.1 Instructions

2.1.1 You may rely on the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

2.1.2 All attachments to this module must be labeled as "Consumer #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Consumer1a, Consumer 1b, etc.

2.1.3 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. New last year and again for this year HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question below in 1.1.5.

2.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

2.2 Alignment of Plan Design

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.2.1 Evidence is emerging that suggests better alignment of consumer incentives through plan design will result in improved plan performance. Examples of this type of alignment include removal or reduction of financial barriers to essential treatments, using comparative evidence analysis to provide a graded scale of copays reflecting the importance/impact of specific treatments, premium reduction or other incentives for members that use higher performing providers (physicians and hospitals), or follow preventive and/or chronic disease management guidelines, etc.

Please describe any efforts that the Plan is currently undertaking or planning for the future. List any limitations in this market on the geographic availability of pilots, incentive designs or high performance networks.

2.2.2 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for preventive or wellness services by any of the means listed in the "Financial incentives" column? In the “Uptake” column, estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes). In the “Product Availability” column, indicate the plan product types in which the incentive feature is available. Check all that apply. a. Account-based means consumer-directed health plan with a health reimbursement account or a high deductible

health plan with a health savings account. b. For "Product availability" column, Plan should select all platforms on which the indicated financial incentives are in place.

Numerator should be the number of members actually enrolled in such a plan design/Denominator is total plan enrollment.

This question does NOT have a regional flag for uptake percentage. Please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a Statewide plan operating in only the market of response, their response would be statewide in this context.

Please respond accordingly in the last column. Plan should provide national data if statewide data are not available.

HMO Response - Preventive and Wellness Services	**Financial Incentives**	**Product availability**	**Uptake as % of total commercial statewide membership noted in 1.3.3**	**Percentage is based on plan's entire commercial membership in all markets of plan operation**
A: Incentives contingent upon member behavior	HEADER	HEADER	HEADER	HEADER
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching prevention goals, 5: Incentives to adhere to evidence-based self-management guidelines, 6: Incentives to adhere to recommended care coordination encounters, 7: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* From 0 to 100. N/A OK.	*Yes/No.*
Participation in other Plan-designated high performance practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Health Assessment (HA)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Participation in weight-loss program (exercise and/or diet/nutrition)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success in weight-loss or maintenance	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Participation in tobacco cessation	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success with tobacco	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

cessation goals				
Participation in wellness health coaching	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success with wellness goals other than weight-loss and tobacco cessation	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
B: Incentives not based on participation or completion				
Well child & adolescent care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Preventive care (e.g. cancer screening, immunizations)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

2.2.3 PPO VERSION OF ABOVE

2.2.4 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for services related to chronic conditions by any of the means listed in the "Financial incentives" column? In the “Uptake” column, estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes). In the “Product Availability” column, indicate the plan product types in which the incentive feature is available.

Numerator should be the number of members actually enrolled in such a plan design/Denominator is total plan enrollment.

This question does NOT have a regional flag for uptake percentage; please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a Statewide plan operating in only the market of response, their response would be statewide in this context. Please respond accordingly in the last column. Plan should provide national data if statewide data are not available.

HMO Response - services related to chronic conditions	**Financial Incentives**	**Product availability**	**Uptake as % of total commercial statewide membership noted in 1.3.3**	**Percentage is based on plan's entire commercial membership in all markets of plan operation**
A: Incentives contingent upon member behavior	HEADER	HEADER	HEADER	HEADER
Participation in Plan-approved Patient-Centered Medical Home Practices	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based	*Percent.* From 0 to 100. N/A OK.	*Yes/No.*

	completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Waived or decreased co-payments/deductibles for reaching biometric goals (e.g., BMI level or change, HbA1c improvement or levels, etc.), 5: Waived or decreased co-payments/deductibles for use of selected chronic care medications, 6: Incentives to adhere to evidence-based self-management guidelines, 7: Incentives to adhere to recommended care coordination encounters, 8: Not supported	plan, 3: Self-funded, 4: Self-funded account-based plan		
Participation in other Plan-designated high performance practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Participation in chronic disease management coaching	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Adherence to chronic disease guidelines (taking tests, drugs, etc. as recommended)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Success with specific target goals for chronic disease management (HbA1c levels, LDL levels, BP levels, etc.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
B: Incentives not based on participation or completion				
Asthma	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Depression	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

2.2.5 PPO VERSION OF ABOVE

2.2.6 Does the Plan currently have plan designs in place that reduce barriers or provide incentives for acute care services by any of the means listed in the "Financial incentives" column? In the “Uptake” column, estimate the percentage of plan members participating in plan designs with the barrier reduction or incentive features for the row topic (e.g. diabetes). In the “Product Availability” column, indicate the plan product types in which the

incentive feature is available. "Acute episodes of care" refers to instances where members might share in the choice of treatment setting or modality (e.g. in-patient vs. outpatient, open vs. Laparoscopic surgery).

Numerator should be the number of members actually enrolled in such a plan design/Denominator is total plan enrollment.

This question does NOT have a regional flag for uptake percentage; please provide the statewide percentage using numbers in numerator and denominator that reflect the plan's entire membership across all markets. For a statewide plan operating in only the market of response, their response would be statewide in this context.

Please respond accordingly in the last column. Plan should provide national data if statewide data are not available.

HMO Response- Acute Care Services	**Financial Incentives**	**Product availability**	**Uptake as % of total commercial statewide membership as noted in 1.3.3**	**Percentage is based on plan's entire commercial membership in all markets of plan operation**
A: Incentives contingent upon member behavior				
Participation in shared decision program prior to proceeding with treatment	*Multi, Checkboxes.* 1: Waive/adjust out-of-pocket payments for tests, treatments, Rx contingent upon completion/participation, 2: Part of program with reduced Premium Share contingent upon completion/participation, 3: Rewards (cash payments, discounts for consumer goods, etc.) administered independently of medical services and contingent upon completion/participation, 4: Not supported	*Multi, Checkboxes.* 1: Fully insured, 2: Fully insured account-based plan, 3: Self-funded, 4: Self-funded account-based plan	*Percent.* From 0 to 100. N/A OK.	*Yes/No.*
B: Incentives not based on participation or completion				
Use of more cost-effective treatment alternatives	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

2.2.7 PPO VERSION OF ABOVE

2.2.8 Please indicate, if any, consumer incentives for use of the following in HMO/POS product:

Consumer Tools/Engagement	Incentives Used in HMO/POS (multiple responses allowed)	Other Description
Use of Web Consultation and other telehealth options	*Multi, Checkboxes.* 1: Agreement with employer on waived or decreased premium share for use, 2: Waived or reduced co-payments or coinsurance, 3: Waived or reduced deductibles, 4: Other (describe), 5: No incentives used	*Unlimited.*
Use of Practitioners who have adopted EMR, ePrescribing or other HIT systems	AS ABOVE	AS ABOVE
Completion & Use of a Personal Health Record (see other questions in section 2.6)	AS ABOVE	AS ABOVE
Use of provider (hospital or physician) selection tools	AS ABOVE	AS ABOVE
Enrollment in PCMH/ACO	AS ABOVE	AS ABOVE
Use of better performing hospitals	AS ABOVE	AS ABOVE
Use of better performing physicians	AS ABOVE	AS ABOVE
Completion and use of registration on the plan's member portal so member can see claims, cost and quality on physicians, etc.	AS ABOVE	AS ABOVE

2.2.9 PPO VERSION OF ABOVE

2.3 Practitioner Information and Connectivity

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.3.1 It is estimated that 50% of adult Americans lack *functional health literacy*, which the U.S. Department of Health and Human Services defines as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is separate from cultural competency and literacy. *An example may be that members understand they need to go to the radiology department to get an X-ray.*

Please describe below plan activities to address health literacy.

Single, Radio group.

1: No activities currently,
2: Plan assesses health literacy of members – Describe criteria for assessment, method of assessment, and testing of materials: [200 words]

2.3.2 If the Plan selects any of the five (5) items in Question 2.3.3 below, provide actual screen prints illustrating ONLY the following: 1) NCQA recognition programs, availability of 2) Web visits, 3) email, 4) ePrescribing or 5) EMRs (electronic medical records) as Consumer 1. Please clearly mark on the documentation the feature listed in Question 2.3.3 that is being demonstrated. Do NOT include attachments that do not specifically demonstrate one of these 5 descriptions. Only provide one demonstration per description.

Multi, Checkboxes.

1: Consumer 1a on NCQA recognition programs is provided,
2: Consumer 1b on use of web visits is provided,
3: Consumer 1c on use of email is provided,
4: Consumer 1d on use of e-prescribing is provided,
5: Consumer 1e on use of EMR is provided,
6: Not provided

2.3.3 Indicate the information available through the Plan's on-line physician directory. These data categories are based on the recommendations of the Commonwealth Fund/NCQA consensus panel on electronic physician directories. Use the detail box to describe any updates (e.g., office hours, languages spoken) that a provider is permitted to make directly through an online provider portal or similar tool.

	Response
Physician office hours	*Single, Pull-down list.* 1: Displayed only, 2: Indexed and searchable, 3: Available from customer service or printed format only, 4: Not available
Physician years in practice	AS ABOVE
Physician facility privileges	AS ABOVE
Physician languages spoken	AS ABOVE
NCQA Diabetes Recognition Program [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify**	AS ABOVE
NCQA Heart/Stroke Recognition Program [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify**	AS ABOVE
NCQA Back Pain Recognition Program [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify**	AS ABOVE
NCQA Physician Practice Connection Recognition [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify**	AS ABOVE
NCQA Patient-Centered Medical Home Recognition [attach documentation] **CHECK one of the choices only if the Plan enters and maintains the information element. Self report from physician practices does not qualify**	AS ABOVE
NCQA Physician Recognition Software Certification - a certification program that supports data collection and reporting for the Diabetes Physician Recognition	AS ABOVE

Program [attach documentation]	
High performance network participation/status	AS ABOVE
Uses web visits [attach documentation]	AS ABOVE
Uses patient email [attach documentation]	AS ABOVE
Uses ePrescribing [attach documentation]	AS ABOVE
Uses EMRs [attach documentation]	AS ABOVE

2.3.4 If the Plan provides a physician selection tool with any of these five (5) interactive features in question 2.3.5 below, provide actual report(s) or screen prints illustrating each interactive feature checked as Consumer 2 for the following; 1) Performance using disease specific individual measures, 2) Performance using disease-specific composite measures, 3) User can rank/filter physician list by culture/demographics, 4) User can rank/filter physician based on HIT adoption, 5) User can rank/filter physician based on quality indicators. Do not provide a copy of the provider directory or replicate information supplied in Question 2.3.2, and do NOT include attachments that do not specifically demonstrate one of these 5 features. Please clearly mark on the documentation the feature listed in Question 2.3.5 that is being demonstrated. Only provide one demonstration per description.

Multi, Checkboxes.

1: Consumer 2a (Performance using disease specific individual measures) is provided,
2: Consumer 2b (Performance using disease-specific composite measures,) is provided,
3: Consumer 2c (User can rank/filter physician list by culture/demographics) is provided,
4: Consumer 2d (User can rank/filter physician based on HIT adoption) is provided,
5: Consumer 2e (User can rank/filter physician based on quality indicators) is provided,
6: Not provided

2.3.5 Indicate the interactive selection features available for members who wish to choose a physician online. Check all that apply, and document the five interactive features checked as available, as Consumer 2 (as noted in 2.3.4).

1) Performance using disease specific individual measures, 2) Performance using disease-specific composite measures, 3) User can rank/filter physician list by culture/demographics, 4) User can rank/filter physician based on HIT adoption, 5) User can rank/filter physician based on quality indicators.

	Response
Availability	*Single, Radio group.* 1: Online Physician Selection Tool is available, 2: Online Physician Selection Tool is not available
Search Features	*Multi, Checkboxes.* 1: User can specify physician proximity to user zip code to limit displayed data, 2: User can limit physician choices to preferred network/coverage status, 3: User can search by treatment and/or condition, 4: None of the above

Content	*Multi, Checkboxes.* 1: User can access information about out-of-network physicians with clear messaging about status and out-of-pocket liability, 2: Performance is summarized using disease specific individual measures, 3: Performance is summarized using disease specific composite measures (combining individual measures that are related), 4: Tool provides user with guidance about physician choice, questions to ask physicians, and questions to ask the Plan, 5: Physician photograph present for at least 50% of physicians, 6: None of the above
Functionality	*Multi, Checkboxes.* 1: User can weight preferences, e.g. quality vs. cost, to personalize results, 2: User can rank physicians based on office hours access (e.g., evening or weekend hours), 3: User can rank or filter physician list by culture/demographics (languages spoken, gender or race/ethnicity), 4: User can rank or filter physician list based on HIT adoption (e.g., e-prescribing, Web visits, EMR use), 5: User can rank or filter physician list based on quality indicator(s), 6: User can compare at least three different physicians/practices side-by-side, 7: Plan directs user (during interactive physician selection session) to cost comparison tools (q.2.7.4) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user), 8: User can link to a physician website, 9: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool indicated to cost calculator and user populates relevant information, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe), 4: There is no integration of cost calculator with this tool
Description of "Other"	*200 words.*

2.3.6 (2.3.7) How does the Plan encourage members to use better performing physicians? Check all that apply.

	Answer
Distinction of higher performing individual physicians	*Single, Radio group.* 1: No distinction, 2: Distinction is made
General education about individual physician performance standards	*Single, Radio group.* 1: Yes, 2: No
Education and information about which individual physicians meet target practice standards	AS ABOVE
Messaging included in EOB if member uses provider not designated as high performing relative to peers	AS ABOVE
Member steerage at the time of nurseline interaction or telephonic treatment option support	AS ABOVE
Members are not actively encouraged at this time to utilize individual physicians that meet targeted practice standards	AS ABOVE

2.3.7 (2.3.8) Provide information regarding the Plan's capabilities to support physician-member consultations using technology (e.g., web consultations, telemedicine). Check all that apply for HMO.

If statewide response is not available, please provide a national response.

HMO Response	Answer	Technology	Geography of response
Plan ability to support web/telehealth consultations	*Multi, Checkboxes.* 1: Plan does not offer/allow web or telehealth consultations, 2: Web visit with structured data input of history and symptom, 3: Telehealth with interactive face to face dialogue over the Web		*Single, Radio group.* 1: Statewide, 2: National
Plan uses a vendor for web/telehealth consultations (indicate vendor)	*50 words.*	*Single, Radio group.* 1: Web, 2: Telehealth, 3: Combination of Web and Telehealth	AS ABOVE
If physicians are designated in provider directory as having Web/Telehealth consultation services available, provide number of physicians in the region	*Decimal.* N/A OK.	AS ABOVE	AS ABOVE
Member reach of physicians providing web/telehealth consultations (i.e., (what % members are attributed to those physicians offering web/telehealth consultations) (use as denominator total commercial membership in market from 1.3.2 or if statewide response from 1.3.3)	*Percent.* N/A OK.	AS ABOVE	AS ABOVE
If members are able to schedule web/telehealth consultations with some physicians, provide percent of members using those physicians (use as denominator total commercial membership in market from 1.3.2 or if statewide response from 1.3.3)	*Percent.* N/A OK. From 0 to 100.	AS ABOVE	AS ABOVE
Number of web/telehealth consultations performed in 2012 per thousand commercial members (based on total commercial membership in 1.3.2 or if statewide response from 1.3.3)	*Decimal.* N/A OK. From 0 to 100000000000.	AS ABOVE	AS ABOVE
Number of web/telehealth consultations performed in 2011 per thousand members	*Decimal.* N/A OK.	AS ABOVE	AS ABOVE
Plan provides a structured template for web/telehealth consultations (versus free flow email)	*Single, Radio group.* 1: Yes, 2: No	AS ABOVE	AS ABOVE
Plan reimburses for web/telehealth consultations	*Single, Radio group.* 1: Yes,	AS ABOVE	AS ABOVE

	2: No		
Plan's web/telehealth consultation services are available to all of members/employers	*Single, Radio group.* 1: Yes - with no additional fee, 2: Yes - sometimes with additional fee, depending on contract, 3: Yes - always for an additional fee, 4: No	AS ABOVE	AS ABOVE

2.3.8 (2.3.9) PPO VERSION OF ABOVE

2.4 Hospital Choice Support

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.4.1 If the Plan provides hospital choice support, attachments are needed to support some of the selections in following question. If any of the following five (5) interactive features are selected in 2.4.2, actual report(s) or screen prints must be attached as Consumer 3.

Provide actual report(s) or screen prints illustrating each interactive feature selected for the following; 1) Distinguishes between condition-specific and hospital-wide performance, 2) Discloses scoring methods, 3) Reports never events, 4) Reports mortality if relevant to treatment, 5) User can weight preferences (e.g. quality vs. cost) to personalize results. The features demonstrated in the attachment must be clearly marked. Reviewers will only be looking for indicated features that are checked below and that are emphasized in the attachment. Do NOT include attachments that do not specifically demonstrate one of these 5 features. Please clearly mark on the documentation the feature listed in Question 2.4.2 that is being demonstrated. Only provide one demonstration per description.

Multi, Checkboxes.

1: Consumer 3a (Distinguishes between condition-specific and hospital-wide performance) is provided,
2: Consumer 3b (Discloses scoring methods) is provided,
3: Consumer 3c (Reports never events) is provided,
4: Consumer 3d (Reports mortality if relevant to treatment) is provided,
5: Consumer 3e (User can weight preferences (e.g. quality vs. cost) to personalize results) is provided,
6: Not provided

2.4.2 Indicate which of the following functions are available with the hospital chooser tool. Check all that apply, and document as the attachment in 2.4.1 as Consumer 3 any of the five (5) interactive features selected below:

1) Distinguishes between condition-specific and hospital-wide performance, 2) Discloses scoring methods, 3) Reports never events, 4) Reports mortality if relevant to treatment, 5) User can weight preferences (e.g. quality vs. cost) to personalize results.

	Answer
Availability	*Single, Radio group.* 1: Hospital chooser tool is available, 2: Hospital chooser tool is not available
Search features	*Multi, Checkboxes.* 1: Supports search for hospital by name, 2: Supports search for hospitals within geographic proximity, 3: Supports hospital-wide attribute search (e.g., number of beds, major service areas, academic medical center, etc.), 4: Supports condition-specific search, 5: Supports procedure-specific search, 6: Supports search for hospital-affiliated physicians, 7: Supports search for hospital-affiliated physicians that are plan contracted, 8: Supports search for plan-affiliated (in-network) hospitals, 9: Supports search for in-network hospital or includes indication of such, 10: None of the above
Content	*Multi, Checkboxes.* 1: Provides education about condition/procedure performance vs. overall hospital performance, 2: Provides education about the pertinent considerations for a specific procedure or condition, 3: Describes treatment/condition for which measures are being reported, 4: Distinguishes between condition-specific and hospital-wide performance, 5: Discloses reference documentation of evidence base for performance metrics (methodology, population, etc.), 6: Discloses scoring methods, (e.g., case mix adjustment, measurement period), 7: Discloses dates of service from which performance data are derived, 8: Reports adherence to Leapfrog patient safety measures, 9: Reports performance on AHRQ patient safety indicators, 10: Reports volume as proxy for outcomes if relevant to treatment, 11: Reports complication indicators if relevant to treatment, 12: Reports never events, 13: Reports HACs (healthcare acquired conditions also known as hospital-acquired conditions) 14: Reports mortality if relevant to treatment, 15: Performance charts or graphics use the same scale for consistent presentation, 16: Communicate absolute risks or performance values rather than relative risks, 17: Some indication of hospital efficiency rating, 18: None of the above
Functionality	*Multi, Checkboxes.* 1: Consumer can weight preferences (e.g. quality vs. cost) to personalize results, 2: Consumer can choose a subset of hospitals to compare on distinct features, 3: Plan directs user (during interactive hospital selection session) to cost comparison tools (q.2.7.4) to determine the financial impact of their selection (specifically customized to the member's benefits, such that co-pays, OOP Max, deductible accumulator, and other financial information are presented to the user) 4: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool to cost calculator and user populates relevant information, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe), 4: There is no integration of cost calculator with this too
Description of "Other"	*200 words.*

2.5 Shared Decision-Making and Treatment Option Support

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.5.1 Does the Plan provide members with any of the following treatment choice support products? Check all that apply.

Multi, Checkboxes.

1: Treatment option support is not available,
2: BestTreatments,
3: HealthDialog Shared Decision Making Program,
4: Healthwise Decision Points,
5: NexCura NexProfiler Tools,
6: Optum Treatment Decision Support,
7: WebMD Condition Centers,
8: Other (name vendor in detail box below):,,
9: Plan provides treatment option support using internal sources,,
10: The service identified above is available subject to an employer buy-up. for HMO,
11: The service identified above is available subject to an employer buy-up. for PPO

2.5.2 If the Plan provides any of the treatment option support capabilities detailed in Question 2.5.3 below, note that attachments are needed to support some of the selections in following question. If any of the following five (5) features are selected, actual report(s) or illustrative screen prints must be attached as Consumer 4:

1) Treatment options include benefits and risks, 2) Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision , 3) Information tailored to the progression of the member's condition, 4) Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, and 5) Linked to the member's benefit coverage to reflect potential out-of-pocket costs. The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features. Health education does not satisfy the documentation requirement. Materials must include discussion of treatment options (e.g., medical management, pharmaceutical intervention, surgical option). Only provide one demonstration per description.

Single, Pull-down list.

1: Consumer 4 is provided,
2: Not provided

2.5.3 Indicate which of the following functions are available with the treatment option decision support tool. Check all that apply and document in the attachment provided as Consumer 4. "Interactive treatment decision support" to help members compare treatment options is defined as interactive tools supported by the Plan where the member enters his/her own personal health or pharmacy information and receives system-generated customized guidance on specific treatment options available. Interactive implies a response mechanism that results in calibration of subsequent interventions. This does not include audio or video information available from the Plan that describes general treatment information on health conditions, or personalized personal health assessment follow up reports that are routinely sent to all members who complete a personal health assessment.

	Answer
Content	*Multi, Checkboxes.* 1: Describes treatment/condition, i.e. symptoms, stages of disease, and expectations/tradeoffs from treatment, 2: Includes information about what the decision factors are with this condition, 3: Treatment options include benefits and risks, 4: Tool includes likely condition/quality of life if no treatment, 5: Includes information about patients' or caregivers' role or responsibilities, 6: Discloses reference documentation of evidence base for treatment option, 7: Provides patient narratives/testimonials so user can consider how patients with similar condition/stage of illness made a decision, 8: Provides member with questions or discussion points to address with provider or enables other follow up option, e.g. health coach option, 9: None of the above
Functionality	*Multi, Checkboxes.* 1: Allows user to organize/rank preferences, 2: User can compare treatment options side-by-side if reasonable options exist, 3: None of the above
Telephonic Support	*Multi, Checkboxes.* 1: Member can initiate call to discuss treatment options with clinician, 2: Plan or vendor may make outbound call to targeted member based on identified triggers (e.g., course of treatment, authorization request, etc.), 3: None of the above
Member Specificity	*Multi, Checkboxes.* 1: Tailored to member's demographic attributes (e.g., age, gender, etc.), 2: Tailored to the progression of the member's condition, 3: Elicits member preferences (e.g., expectations for survival/recurrence rates, tolerance for side effects, patient's role within each course of treatment, etc.), 4: Tailored to member's specific benefits design, such that co-pays, OOP Max, deductible, FSA and HSA available funds, and relevant tiered networks or reference pricing are all present in cost information 5: None of the above
Cost Information/functionality	*Multi, Checkboxes.* 1: Treatment cost calculator based on the Plan's fee schedule but not tied to selection of specific providers, 2: Treatment cost calculator based on the Plan's fee schedule and selection of specific providers, 3: Treatment cost calculator based on billed charges in the local market, 4: Treatment cost calculator based on paid charges in the local market, 5: Specific to the member's benefit coverage (co-pays, OOP Max, deductible, FSA and HAS available funds) to reflect potential out-of-pocket costs, 6: Treatment cost calculator includes medication costs, 7: Treatment cost calculator does not include medication costs – information is not integrated, 8: Treatment cost per an alternative method not listed above (describe in detail box below):, 9: None of the above
Interface/Integration Of Cost Calculator	*Multi, Checkboxes.* 1: There is a link from tool to cost calculator and user populates relevant information,, 2: Cost calculator is integrated and contains relevant results from searches of other tools, 3: Other (describe in detail box below), 4: There is no integration of cost calculator with this tool
Description of "Other"	*200 words.*

2.5.4 Does the plan use any of the following activities to identify members who would benefit from treatment decision support? Check all that apply.

Multi, Checkboxes.

1: Claims or clinical record profiling,
2: Specialty care referral process,
3: Health Assessment,
4: Nurse advice line referral,
5: Care/case management support,
6: None of the above activities are used to identify specific treatment option decision support outreach

2.5.5 Does the Plan provide its network physicians with services that encourage physicians to engage patients in treatment decision support. Check all that apply.

Multi, Checkboxes.
1: Point of service physician decision support (e.g., reminders tagged to patients considering selected therapies like surgery for back pain, hysterectomy, bariatric surgery),
2: Routine reporting to physicians that identifies patient candidates for treatment decision support,
3: Patient communication aids (e.g., tear-off treatment tool referral),
4: None of the above services are used to help engage members in treatment decision support

2.5.6 How does the Plan evaluate the use and impact of its treatment option support? The commercial enrollment reported below should match the statewide number reported in Profile.

	2012	**2011**
Use/impact not evaluated or tool not available	*Multi, Checkboxes - optional.* 1: Not available	*Multi, Checkboxes - optional.* 1: Not available
Total commercial enrollment from plan's response in profile 1.3.3 (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison.* 0	
Enrollment (denominator used to calculate percentage of unique users and ideally should be the total commercial state enrollment. If use can only be tracked nationally, enrollment number here should be the total commercial national number. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*Decimal.*	*Decimal.*
Number of completed interactive sessions with treatment option support tool	*Decimal.* From 0 to 10000000000000. N/A OK.	*Decimal.* From 0 to 10000000000000. N/A OK.
Number of unique users to site	*Decimal.* From 0 to 1000000000. N/A OK.	*Decimal.* From 0 to 1000000000. N/A OK.
Number of unique users making inbound telephone calls	*Decimal.* N/A OK.	*Decimal.* N/A OK.
Number of unique users receiving outbound telephone calls	*Decimal.* N/A OK.	*Decimal.* N/A OK.
Percentage of unique Website users to total enrollment [autocalc]	*For comparison.* 0.00%	*For comparison.* 0.00%
Percentage of unique users for telephonic treatment option decision support (inbound and outbound) [autocalc]	*For comparison.* 0.00%	*For comparison.* 0.00%
Targeted follow-up via email or phone call to assess user satisfaction	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Yes, 2: No
Measuring change in utilization patterns for preference-sensitive services (e.g., back surgery, prostate surgery, etc.)	*Multi, Checkboxes.* 1: Volume of procedures, 2: Paid claims, 3: None of the above	*Multi, Checkboxes.* 1: Volume of procedures, 2: Paid claims, 3: None of the above
Plan can report utilization aggregated at the purchaser level	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Yes, 2: No

2.5.7 (2.5.11) For the commercial book of business please indicate if the health plan provides any of the services below and indicate whether such services are internally developed or contracted. In the detail box, provide a description of the health plan's strategy to incorporate social media as a consumer engagement and decision support tool, including program metrics and evaluation criteria

	Service Provided	Name external vendor or Apps and/or pilot markets	Date Implemented	Access / Availability
Online discussion forum for member feedback	*Multi, Checkboxes.* 1: Internally developed, 2: External vendor - name vendor in following column, 3: Service not provided, 4: Service being piloted - list location in following column	*200 words.*	*To the day.* From Jan 01, 1980 to Jan 01, 2020.	*Multi, Checkboxes.* 1: Standard benefit for all fully insured lives (included in fully insured premium), 2: Standard benefit for all self insured ASO lives (no additional fee), 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members
Mobile applications for self-care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Mobile applications for self-care and automated biometric tracking	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Interactive consumer-to-consumer information exchange and support	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Condition-specific information feed (e.g., phone text health reminders)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other (describe below)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

2.6 Electronic Personal Health Record (PHR)

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.6.1 Describe the Plans electronic personal health record.

	Answer
PHR availability	*Multi, Checkboxes.* 1: PHR not offered, 2: PHR not

	supported, 3: PHR supported
Plan promotes PHR available in the market through a provider-based effort (describe up to 200 word limit)	*200 words.*
Plan promotes PHR available in the market through an independent Web-based effort (list partners and describe up to 200 word limit)	*200 words.*

2.6.2 If any of the PHR functionality listed in the question below is available on the Plan's online system, note that attachments (Consumer 5) are needed to support some of the selections in following question.

If the Plan provides any of the following five PHR capabilities identified in Question 2.6.3 below, provide actual, blinded screen prints as Consumer 5: 1)Targeted push message to member based on member profile, 2) Member can elect to electronically share selected PHR information with their physicians or facilities, 3) Drug checker automatically checks for contraindications for drugs being used and notifies member, 4) Member can electronically chart and trend vital signs and other relevant physiologic values, and 5) Member defines conditions for push-messages or personal reminders from the Plan. The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features.

Single, Pull-down list.
1: Consumer 5 is provided,
2: Not provided

2.6.3 Indicate the features and functions the Plan provides to members within an electronic PHR. Features and functions that are not personalized or interactive do not qualify for credit. Check all that apply.

	Answer
Content	*Multi, Checkboxes.* 1: Demographic and personal information, emergency contacts, PCP name and contact information, etc., 2: Possible health risks based on familial risk assessment. Includes the relationship, condition or symptom, status (e.g. active/inactive), and source of the data, 3: Physiological characteristics such as blood type, height, weight, etc., 4: Member lifestyle, such as smoking, alcohol consumption, substance abuse, etc., 5: Member's allergy and adverse reaction information, 6: Advance directives documented for the patient for intubation, resuscitation, IV fluid, life support, references to power of attorneys or other health care documents, etc., 7: Information regarding any subscribers associated with the individual (spouse, children), 8: OTC Drugs, 9: Information regarding immunizations such as vaccine name, vaccination date, expiration date, manufacturer, etc., 10: None of the above
Functionality	*Multi, Checkboxes.* 1: Plan initiates targeted push-messages to member based on member profile, 2: Member can electronically populate the PHR with biometrics (BP, weight, etc.) through direct feed from a biometric device or wearable sensor, 3: Member can use PHR as a communication platform for physician email or web visits, 4: Member can elect to electronically share all PHR information with their physicians or facilities, 5: Member can elect to electronically share selected PHR information with their physicians or facilities, 6: Alerts resulting from drug conflicts or biometric outlier results are automatically pushed to a clinician, 7: Drug checker automatically checks for contraindications for drugs being used and notifies member, 8: None of the above
Member	*Multi, Checkboxes.*

Specificity	1: Member can electronically chart and trend vital signs and other relevant physiologic values, 2: Member can collect and organize personalized member-specific information in actionable ways (e.g. daily routines to manage condition, how to prepare for a doctor's visit), 3: Member defines conditions for push-messages or personal reminders from the Plan, 4: None of the above
Data that is electronically populated by Plan	*Multi, Checkboxes.* 1: Information regarding current insurance benefits such as eligibility status, co-pays, deductibles, etc., 2: Prior medication history such as medication name, prescription date, dosage, pharmacy contact information, etc., 3: Plan's prescription fill history including date of each fill, drug name, drug strength and daily dose, 4: Historical health plan information used for plan to plan PHR transfer., 5: Information regarding clinicians who have provided services to the individual, 6: Information regarding facilities where individual has received services, 7: Encounter data in inpatient or outpatient settings for diagnoses, procedures, and prescriptions prescribed in association with the encounter, 8: Any reminder, order, and prescription, etc. recommended by the care management and disease management program for the patient., 9: Lab tests completed, with push notification to member 10: Lab values, with push notification to member 11: X-ray interpretations, with push notification to member 12: None of the above

2.6.4 Is the PHR portable, enabling electronic member data transfer upon Plan disenrollment? Check all that apply.

Multi, Checkboxes.

1: No, but information may be printed or exported as a pdf file by member,
2: Yes, the plan provides electronic files that can be uploaded to other PHR programs. (specify other programs in detail box below),
3: Yes, the plan provides software that can be used at home,
4: Yes, the vendor/Plan allows continued use on an individual basis at no charge,
5: Yes, the vendor/Plan makes this available for continued use for a charge,
6: PHR is not portable

2.7 Claims Management and Price Transparency

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.7.1 Describe activities to identify for members/consumers those providers (hospitals and/or physicians) that are more efficient and/or lower cost.

Single, Radio group.

1: Description:,
2: Plan does not identify those providers (hospitals and/or physicians) that are more efficient and/or lower cost

2.7.2 Describe the web-based cost information that the Plan makes available for physician and hospital services. Check all that apply.

	Physicians	**Hospitals**	**Ambulatory surgery or diagnostic centers**
Procedure-based cost	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Statewide or provider average billed charges, 4: Statewide or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Statewide or provider average billed charges, 4: Statewide or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members,	*Multi, Checkboxes.* 1: National average billed charges, 2: National average paid charges, 3: Statewide or provider average billed charges, 4: Statewide or provider average paid charges, 5: Provider specific contracted rates, 6: Cost information not available, 7: Information available only to members,

	members, 8: Information available to public	8: Information available to public	8: Information available to public
Episode of care based cost (e.g. vaginal birth, bariatric surgery)	AS ABOVE	AS ABOVE	AS ABOVE

2.7.3 If any of the Cost Calculator functionality listed in question 2.7.4 below is selected as available on the Plan's online system, note that attachments are needed to support some of the selections in following question. If any of the following four (4) features are selected, actual report(s) or illustrative screen prints must be attached as Consumer 6:

1) Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions,

2) Cost information considers members benefit design relative to accumulated deductibles, OOP max, service limits,

3) Supports member customization of expected ***professional*** services utilization or medication utilization,

4) Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses. The functionality demonstrated in the attachment must be clearly marked. Do NOT include attachments that do not specifically demonstrate one of these features

Single, Pull-down list.
1: Consumer 6 is provided,
2: Not provided

2.7.4 Indicate if the following functionality is available in the Plan's cost calculator. Check all that apply.

	Answer
	Multi, Checkboxes - optional. 1: The Plan does not support a cost calculator.
Content	*Multi, Checkboxes.* 1: Medical cost searchable by procedure (indicate number of procedures in detail box below), 2: Medical cost searchable by episode of care (indicate number of care episodes in detail box below), 3: Medication costs searchable by drug, 4: Medication costs searchable by episode of care, 5: None of the above
Functionality	*Multi, Checkboxes.* 1: Compare costs of alternative treatments, 2: Compare costs of physicians, 3: Compare costs of hospitals, 4: Compare costs of ambulatory surgical or diagnostic centers, 5: Compare drugs, e.g. therapeutic alternatives, 6: Compare costs based on entire bundle of care, allowing user to substitute lower cost or higher quality equivalent elements of bundle, 7: ,.None of the above
Member Specificity	*Multi, Checkboxes.* 1: Cost information considers members benefit design relative to copays, cost sharing, coverage exceptions, 2: Cost information considers members benefit design relative to accumulated deductibles, Out of Pocket max, lifetime, services limits (e.g. number of physical therapy visits covered), 3: Cost information considers members benefit design relative to pharmacy benefit, e.g. brand/generic and retail/mail,

	4: Separate service category sets result for user, other adult household members and for children, 5: Explains key coverage rules such as family-level versus individual-level annual accumulation and general rules about portability, accrual, tax allowances, etc., 6: Provides summary plan benefits description as linked content with explanatory note about IRS-allowed expenses vs. deductible-applicable covered expenses, 7: Supports member customization of expected services or medications utilization, i.e. member can adjust the default assumptions, 8: None of the above
Account management / functionality	*Multi, Checkboxes.* 1: Supports member entry of tax status/rate to calculate federal/state tax ramifications, 2: Member can view multi-year HSA balances, 3: Calculates a recommended amount for FSA/HSA contribution given anticipated medical expenses, 4: None of the above

2.8 Performance Measurement

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 2.9.

2.8.1 Review the Plan's HMO CAHPS ratings for the following composite measures. Note only 9 & 10 responses provided and not the 8, 9, & 10 responses.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	HMO QC 2012	**HMO QC 2011**
Rating of Health Plan (9+10)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Rating of All Health Care (9+10)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

2.8.2 PPO VERSION OF ABOVE

2.8.3 Review the Plan's HMO CAHPS ratings for the following composite measures.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and

-4 means 'EXC'

This answer is auto-populated.

	HMO QC 2012	HMO QC 2011
Getting needed care composite **Provide percentage of members who responded “Always” or “Usually”**	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Getting care quickly composite **Provide percentage of members who responded “Always” or “Usually”**	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Customer service composite **Provide percentage of members who responded “Always” or “Usually”**	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Shared Decision Making Composite **Percentage who gave “Definitely Yes” responses**	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

2.8.4 PPO VERSION OF ABOVE

2.8.5 Review the Plan's HMO CAHPS ratings for the following member communication measures. (CAHPS 29 and CAHPS 8). If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

Provide percentage of members who responded “Always” or “Usually”	**HMO QC 2012**	**HMO QC 2011**
Survey Item: How often did the written materials or the Internet provide the information you needed about how your health plan works?	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Survey Item: How often did you and a doctor or other health provider talk about specific things you could do to prevent illness?	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

2.8.6 PPO VERSION OF ABOVE

2.9 Other Information

2.9.1 If the Plan would like to provide additional information about its approach to Consumer Engagement that was not reflected in this section, provide as Consumer 7.

3 Provider Measurement and Reporting

The following questions have been added to update and simplify existing questions regarding Provider Measurement and Rewards: 1.5.3, 3.5.1, 3.5.4, 3.5.7, 3.5.8, 3.7.1, 3.7.2, 3.7.6. They were developed in collaboration with Catalyst for Payment Reform (CPR).

CPR has received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses in questions. Information on the National Scorecard and Compendium can be found at http://catalyzepaymentreform.org/National_Scorecard.html

The CPR California Payment Reform Scorecard will report an aggregate result, e.g. "In 2012, x% of total in-network dollars were paid out as payment reform." - no plans will be identified.

The description of the payment reform programs in 3.5.1 and 3.7.1 will be reported publicly as part of CPR's Compendium for Payment Reform. Plans can opt out of having their program information reported publicly

3.1 Instructions

3.1.1 You may rely on the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

3.1.2 All attachments to this module must be labeled as "Provider #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Provider 1a, Provider 1b, etc.

3.1.3 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. New last year and again for this year HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question below in 1.1.5.

3.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

3.2 Community Collaboration for Provider Measurement

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 3.9.

3.2.1 Is the Plan engaged in any of the following nationally organized programs in the market of this RFI response? Identify other markets of engagement. If the Plan engages in California Hospital Assessment and Reporting Taskforce (CHART) or Integrated Healthcare Association (IHA), please indicate in the Other category below.

Note that selection of "Not Engaged in Any Programs" will lock-out the responses for all rows and columns in this question.

	Engaged in any market/region	**Engaged in this market**	**Other markets in which engaged**
The Plan is not engaged in any of the below programs	*Multi, Checkboxes - optional.* 1: Not Engaged in Any Programs		
Leapfrog Hospital Rewards Program	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*Single, Radio group.* 1: Engaged, 2: Not Engaged	*50 words.*
Prometheus	AS ABOVE	AS ABOVE	AS ABOVE
Bridges to Excellence	AS ABOVE	AS ABOVE	AS ABOVE
Aligning Forces for Quality	AS ABOVE	AS ABOVE	AS ABOVE
Chartered Value Exchange	AS ABOVE	AS ABOVE	AS ABOVE
Health Map RX (Asheville Project)	AS ABOVE	AS ABOVE	AS ABOVE
Multi-payer Medical Home (name additional payers in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Accountable care organizations (name additional payers in detail box)	AS ABOVE	AS ABOVE	AS ABOVE
Purchaser-organized programs (e.g., Xerox in Rochester, NY) described in detail box	AS ABOVE	AS ABOVE	AS ABOVE
California Health Performance Initiative	AS ABOVE	AS ABOVE	AS ABOVE
Healthcare Association (IHA) Pay for Performance Program workgroup.	AS ABOVE	AS ABOVE	AS ABOVE

IHA Division of Financial Responsibility (DOFR) (Describe in detail box your organization's current use, if any, of DOFRs with providers. If applicable, identify the percentage of providers utilizing DOFRs and describe any plans to increase usage.)	AS ABOVE	AS ABOVE	AS ABOVE
Other (described in detail box)	AS ABOVE	AS ABOVE	AS ABOVE

3.2.2 Identify community collaborative activities with local health plans and/or purchasers on implementation of data pooling and/or agreement on common measures to support variety of plan activities noted below (such as consumer reporting) in the local market for this RFI response. Collaboration solely with a parent/owner organization or Plan vendors does NOT qualify for credit. Name the other participants for each collaboration. Implementation refers to the go-live date marking the beginning of use of the data for the listed purpose**.** A given activity can be reported for credit as long as data continues to be actively pooled for the stated purpose. Plans are also given the opportunity to report on programs that have been implemented by the date of the RFI submission

	Types of measures used in activity selected by plan	**Name of participating Organizations**
Pooling data for physician feedback and benchmarking – implemented and in place at time of RFI submission	*Multi, Checkboxes.* 1: AQA Clinical Process Measures (.e.g., HbA1c testing, preventive screenings), 2: AQA Clinical Outcome Measures (e.g. blood pressure control, LDL <100), 3: Non-AQA clinical quality measures, 4: Standardized measures of patient experience, 5: Standardized measures of episode treatment efficiency, 6: None of the above	*100 words.*
Pooling data for consumer reporting – implemented and in place at time of RFI submission	AS ABOVE	AS ABOVE
Pooling data for payment rewards – implemented and in place at time of RFI submission	AS ABOVE	AS ABOVE
Pooling data to generate actionable member-specific reminders – implemented and in place at time of RFI submission	AS ABOVE	AS ABOVE
Agreement on common measures for payment rewards in place at time of RFI submission	AS ABOVE	AS ABOVE
Agreement on common measures for consumer reporting in place at time of RFI submission	AS ABOVE	AS ABOVE

3.2.3 Identify community collaborative activities with local health plans on related to agreement on a set of common measures or other collaborations in implementation for the following hospital performance-related activities (e.g., payment rewards, consumer reporting). If the State provides hospital reports or the Plan is citing CMS Hospital

Compare as its source of collaboration, that source may be claimed as collaboration ONLY IF ALL of the collaborating plans: 1) have agreed on a common approach to the use of State/CMS data by selecting which indicators to use (all or a specific subset) 2) use the State/CMS indicators/data for incentives and/or reporting, and if used for reporting, 3) have at least a hyperlink to the State's/CMS's public reports.

The Leapfrog Group includes private and public health care purchasers that provide health benefits to more than 34 million Americans and spend more than $60 billion on health care annually. Information on the four Leapfrog safety practices (CPOE, Evidence-Based Hospital Referral, ICU Physician Staffing, and NQF-endorsed Safe Practices) is available at http://www.leapfroggroup.org/for_hospitals/leapfrog_hospital_survey_copy/leapfrog_safety_practices. Name participants for each collaboration. Agreement must be in place by time of submission for credit to be awarded. If activity has been implemented based on agreement, respond in agreement row and note the implementation date in last column Name the participants for each collaboration. “Implementation” refers to the ‘go-live' date marking the beginning of use of the data for the listed purpose. A given activity can be reported for credit as long as data continues to be actively pooled for the stated purpose. Plans are given the opportunity to report on programs that have been implemented by the date of the RFI submission.

	Types of Measures used in the activity selected by the plan	**Name of participating Organizations and description of “other collaboration” in 3rd row**
Link to CMS Website only	*Single, Radio group.* 1: Yes, 2: No	
Agreement on common measures for payment rewards in place at time of RFI submission	*Multi, Checkboxes.* 1: HQA clinical process measures, 2: Leapfrog measures, 3: Other quality measures endorsed by NQF, 4: Quality outcomes measures (e.g., mortality rates), 5: Standardized measures for patient experience (e.g., H-CAHPS), 6: Efficiency measures, 7: None of the above	*100 words.*
Agreement on common measures for consumer reporting in place at time of RFI submission	AS ABOVE	AS ABOVE
Other collaboration to support hospital performance improvement in place at time of RFI submission (describe collaboration as well as participating organizations in last column)	AS ABOVE	AS ABOVE

3.3 Physician Support and HIT

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 3.9.

3.3.1 (3.3.3) How does the Plan PROMOTE the availability and encourage use of specialist physician performance data to primary care physicians? Check all that apply.

Multi, Checkboxes.

1: Physician newsletter,

2: Targeted communication (mailing, email, fax alert),

3: Prominent placement on physician web portal,

4: Incorporated in online physician referral request,

5: Availability of specialist performance information is not promoted to PCPs in any of the above ways,

6: Individual or practice site results for specialists exist but are not shared with PCPs,

7: None of the above

3.3.2 (3.3.4) How does the Plan PROMOTE the availability and encourage use of hospital performance data by physicians?

Note that responses to this question need to be supported by attachments (e.g., if plan selects response option #2 – plan needs to attach a sample of the targeted communication to the physician)

Multi, Checkboxes.

1: Physician newsletter,

2: Targeted communication (mailing, email, fax alert),

3: Prominent placement on physician web portal,

4: Incorporated in inpatient prior authorization or notification system,

5: Hospital performance information is not promoted to PCPs in any of the above ways,

6: Hospital performance information is not shared with PCPs

3.3.3 (3.3.5) Please attach all communication materials and relevant screen prints from the online system to support Plan's response in 3.3.2 (above) as Provider 1.

3.4 Physician Performance Measurement and Reporting

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided at the end of the Section, in Item 3.9.

3.4.1 Purchasers expect that health plans implementing physician transparency and performance-based payment initiatives are in compliance with the Consumer-Purchaser Disclosure Project's "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (see http://www.healthcaredisclosure.org/docs/files/PatientCharter.pdf). One approach to complying with the Disclosure Project's "Patient Charter" is to meet the measurement criteria specified in the NCQA Physician and Hospital Quality Standards (available at http://www.ncqa.org). Respondents are asked to confirm if they are in compliance with the Patient Charter.

Multi, Checkboxes.

1: Plan is not in compliance with the Patient Charter,

2: Plan is in compliance with some/all of the following elements of the Patient Charter: [Multi, Checkboxes],

3: Plan uses own criteria [200 words],

4: Plan meets the measurement criteria specified in the NCQA PHQ standards,

5: Plan does not meet the NCQA PHQ standards

3.4.2 If plan is measuring and reporting on physician performance, provide information in table below on network physicians that are being measured and reported on. Use the same time 12 month period as was used in 1.5.3, 3.4.2, 3.5.4, 3.5.7, 3.5.8, 3.7.2, 3.7.5 and 3.7.6

One approach to meeting the Consumer-Purchaser Disclosure Project "Patient Charter" for Physician Performance Measurement, Reporting and Tiering Programs (available at http://www.healthcaredisclosure.org/docs/files/PatientCharter.pdf) is meeting the measurement criteria specified in the NCQA Physician and Hospital Quality Standards

(available at http://www.ncqa.org/Programs/Certification/PhysicianandHospitalQualityPHQ.aspx).

Response for commercial book of business	Response	Autocalculation
Total number of PCP physicians in network	*Decimal.*	
Total number of PCP physicians in network for whom the measurement results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Decimal.* From 0 to 1000000000. N/A OK.	*For comparison.* 0.00%
Total $ value of claims paid to all PCP physicians in network	*Dollars.*	
Total $ value of claims paid to those PCP physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Dollars.* From 0 to 1000000000. N/A OK.	*For comparison.* 0.00%
Total number of Specialty physicians in network	*Decimal.*	
Total number of Specialty physicians in network for whom the measurement results meet credibility/reliability thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Decimal.* From 0 to 1000000000. N/A OK.	*For comparison.* 0.00%
Total $ value of claims paid to all Specialty physicians in network	*Dollars.*	
Total $ value of claims paid those Specialty physicians in network who meet the thresholds under standards that meet the Patient Charter (e.g., NCQA PHQ threshold of 30 episodes or .7 reliability)	*Dollars.* From 0 to 1000000000. N/A OK.	*For comparison.* 0.00%

3.4.3 Attach as Provider 2 feedback reports, screen shots, etc. that support each of the reporting elements (provider feedback and/or public information) indicated in question below (3.4.4 or 3.4.5) Data contained in these reports must (1) be physician- or medical group-specific, (2) reflect each of the reported elements, (3) include benchmark or target result identified, and (4) labeled or highlighted for ease of review.

Note that plan does not need to provide support for every row selected – only one example from each category (one from A, one from B, etc.)

3.4.4 For the HMO, indicate if public reports comparing physician (primary care and/or specialty) quality performance are available and used for any of the following categories of PQRS Measure Groups and other additional measures. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars).

Numerator: the number of physicians for which performance information is able to be calculated based on threshold of reliability (not just those informed about reporting)

Denominator (preferred): all PCPs in network and relevant specialists in network that would treat the condition

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in network – please insert this number in appropriate column - newly created last column

Only one of the last two columns needs a %response – system will not allow plan to save responses if both of the last 2 columns have responses

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf

"Advancing Physician Performance Measurement: Using Administrative Data to Assess Physician Quality and Efficiency" http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

Category of PQRS Measure & Other Measures	**Level of detail for comparative public reporting of physicians who meet the threshold of reliability for reporting. (HMO)**	**Indicate if reporting covers primary care and/or specialty physicians (HMO)**	**Description of Other (if plan selected response option 6)**	**(preferred) Physicians (PCP and SCP) in the relevant specialties being reported on as % of total contracted physicians (Denominator = all PCPs and relevant specialists) (HMO)**	**(alternate) Physicians being reported on as % total contracted physicians in market (Denominator = all PCPs and all specialists in network) (HMO)**
Diabetes Mellitus (A)	*Multi, Checkboxes.* 1: Individual Physician, 2: Practice Site, 3: Medical Group/IPA/Staff model Group, 4: PCMH, 5: ACO, 6: Other (describe), 7: None of the above	*Multi, Checkboxes.* 1: Primary care, 2: Specialty	*50 words.*	*Percent.* From 0 to 100. N/A OK.	*Percent.* From 0 to 100. N/A OK.
Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention) (B)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

Coronary Artery Bypass Graft (C)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Perioperative Care (C)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Back pain (A)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Coronary Artery Disease (A)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Heart Failure (A)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Community-Acquired Pneumonia (D)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma (A)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
NCQA Recognition program certification (consistent with plan response in directory section) ((E)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Patient experience survey data (e.g., A-CAHPS) (F)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Mortality or complication rates where applicable (G)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Efficiency (resource use not unit cost) (H)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pharmacy management (e.g. generic use rate, formulary compliance) (I)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Medication Safety (J)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Health IT adoption/use (K)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

3.4.5 PPO VERSION OF ABOVE

3.5 Physician/Practice Site and Medical Group/IPA Value Differentiation and Payment Rewards

Additional information that Bidder wishes to provide that is not addressed elsewhere within this section can be provided in at the end of the Section, Item 3.9.

The following questions have been added to update and simplify existing questions regarding Provider Measurement and Rewards: 1.5.3, 3.5.1, 3.5.4, 3.5.7, 3.5.8, 3.7.1, 3.7.2, 3.7.6. They were developed in collaboration with Catalyst for Payment Reform CPR has received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses in questions. Information on the National Scorecard and Compendium can be found at http://catalyzepaymentreform.org/uploads/Tracking_Progress_Summary.pdf

The CPR California Payment Reform Scorecard will report an aggregate result, e.g. "In 2012, x% of total in-network dollars were paid out as payment reform." - no plans will be identified.

The description of the payment reform programs in 3.5.1 and 3.7.1 will be reported publicly as part of CPR's Compendium for Payment Reform. Plans can opt out of having their program information reported publicly

3.5.1 Purchasers are under significant pressure to address the dual goals of ensuring participants access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems. These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, reduced payment or no longer elevating payment for HACs or preventable complications that occur during the course of care, narrow/tiered performance-based networks and reference pricing, among others.

For your entire commercial book of business, describe below any current payment approaches for physician (primary care and or specialty) outpatient services that align financial incentives with reducing waste and/or improving quality or efficiency. ***Please refer to response in question 3.5.4.***

If there is more than one payment reform program involving outpatient services, please provide in the additional columns

If plan does not have any programs in market of response, please provide information on a program in the closest market to market of response, and also provide information on any programs you plan to implement in market of response within the next 6 months.

In addition to being summarized for site visits, answers to this question will be also used to help create the Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which will be an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform will be a publicly available valuable resource for plans and employers to highlight innovative health plan or program entity programs. If you do not want this information to be used in the Compendium, please opt-out by checking the box in the last response row. ***This question replaces 3.4.1 and section 3.10 from eValue8 2012.***

	Program 1	Other markets/details for Program 1	Program 2	Other markets/details for Program 2
Name of Payment Reform Program and Name and contact details (email and phone) of contact person who can answer questions about program being described	*65 words.*	N/A	*65 words.*	N/A
Geography of named	*Single, Radio group.*	*Multi, List box.*	*Single, Radio group.*	*Multi, List box.*

payment reform program (Ctrl-Click for multiple states)	1: Not in this market (Identify market in column to the right), 2: In this market and other markets (Identify market(s) in column to the right), 3: Only in this market	1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, 6: Colorado, 7: Connecticut, 8: Delaware, 9: Florida, 10: Georgia, 11: Hawaii, 12: Idaho, 13: Illinois, 14: Indiana, 15: Iowa, 16: Kansas, 17: Kentucky, 18: Louisiana, 19: Maine, 20: Maryland, 21: Massachusetts, 22: Michigan, 23: Minnesota, 24: Mississippi, 25: Missouri, 26: Montana, 27: Nebraska, 28: Nevada, 29: New Hampshire, 30: New Jersey, 31: New Mexico, 32: New York, 33: North Carolina, 34: North Dakota, 35: Ohio, 36: Oklahoma, 37: Oregon, 38: Pennsylvania, 39: Rhode Island, 40: South Carolina, 41: South Dakota, 42: Tennessee, 43: Texas, 44: Utah, 45: Vermont, 46: Virginia, 47: Washington State, 48: Washington D.C., 49: West Virginia, 50: Wisconsin, 51: Wyoming	1: Not in this market (Identify market in column to the right), 2: Only in this market, 3: In this market and other markets (Identify markets in column to the right)	1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, 6: Colorado, 7: Connecticut, 8: Delaware, 9: Florida, 10: Georgia, 11: Hawaii, 12: Idaho, 13: Illinois, 14: Indiana, 15: Iowa, 16: Kansas, 17: Kentucky, 18: Louisiana, 19: Maine, 20: Maryland, 21: Massachusetts, 22: Michigan, 23: Minnesota, 24: Mississippi, 25: Missouri, 26: Montana, 27: Nebraska, 28: Nevada, 29: New Hampshire, 30: New Jersey, 31: New Mexico, 32: New York, 33: North Carolina, 34: North Dakota, 35: Ohio, 36: Oklahoma, 37: Oregon, 38: Pennsylvania, 39: Rhode Island, 40: South Carolina, 41: South Dakota, 42: Tennessee, 43: Texas, 44: Utah, 45: Vermont, 46: Virginia, 47: Washington State, 48: Washington D.C., 49: West Virginia, 50: Wisconsin, 51: Wyoming
Summary/Brief description of Program (500 words)	*500 words.*	N/A	*500 words.*	N/A
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*
What is current stage of implementation? Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the minute.*	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the minute.*
To which payment reform	*Single, Radio group.*	*65 words.*	*Single, Radio group.*	*65 words.*

model does your program most closely align?	1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)		1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled/episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8 Other - (provide details in next column)	*100 words.*	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled/episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8 Other - (provide details in next column)	*100 words.*
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*100 words.*	*Multi, Checkboxes.* 1: Primary care physicians, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*100 words.*
If you have a payment reform model that includes policies on non-payment for specific services associated with complications that were preventable or services that were unnecessary, for which outcomes are these policies in place?	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions, 3: Healthcare/hospital-acquired conditions(HACs), 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)	*65 words.*	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions, 3: Healthcare/hospital-acquired conditions (HACs), 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)	*65 words.*
Which of the following sets of performance measures does your program use?	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g.,	*100 words.*	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g.,	*100 words.*

	Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)		Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	
Indicate the type(s) of benefit and/or provider network design features that create member incentives or disincentives to support the payment reform program.	*Multi, Checkboxes.* 1: Mandatory use of COE or higher performing providers, 2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers, 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 4: Use of tiered/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: Other (please describe)	*100 words.*	*Multi, Checkboxes.* 1: Use of COE or higher performing providers required for coverage, 2: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 3: Use of tiered/high performance or narrow networks, 4: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 5: No active steerage, 6: No COE or high performing providers program, 7: Other (please describe)	*100 words.*
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or efficiency measures at the provider level?	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*100 words.*	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*100 words.*
Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*500 words.*	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*500 words.*
Do not include this information in the National	*Multi, Checkboxes - optional.* 1: X			

Compendium on Payment Reform				

3.5.2 For HMO, indicate if payment rewards for physician (primary care and/or specialty) quality performance is assessed and used for any of the following categories of PQRS Measure Groups and other measures. Check all that apply. Note that results must be available to compare across at least two entities. Plan level measurement is insufficient to meet the intent of this expectation. Measures may be used individually or in composite (aggregate performance on several diabetes measures) and may be assessed with the actual value or with a relative performance level (report actual rate or interpreted result on a scale such as 1-5 stars).

Denominator (preferred): all PCPs in network and relevant specialists in network that would treat the condition

Denominator (alternate if cannot tease out relevant specialist): all PCPs and specialists in network – please insert this number in appropriate column - newly created last column

Only one of the last two columns needs a %response – system will not allow plan to save responses if both of the last 2 columns have responses.

For additional information, see:
http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf

http://www.pbgh.org/storage/documents/reports/PBGHP3Report_09-01-05final.pdf

http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

Category of PQRS Measure & Other Measures	**Level/system at which reward is assessed/ paid (HMO)**	**Indicate if rewards available to primary care and/or specialty physicians (HMO)**	**Description of Other (HMO)**	**(Preferred) % total contracted physicians in market receiving reward (Denominator = all PCPs and relevant specialists) (HMO)**	**(Alternate) % total contracted physicians in market receiving reward (Denominator = all PCPs and all specialists in network) (HMO)**
Diabetes Mellitus	*Multi, Checkboxes.* 1: Individual Physician, 2: Practice Site, 3: Medical Group/IPA/Staff model Group, 4: PCMH, 5: ACO, 6: Other (describe), 7: None of the above	*Multi, Checkboxes.* 1: Primary care, 2: Specialty	*50 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.

Preventive Care (Osteoporosis screening, urinary incontinence, flu shot, pneumonia vaccination, screening mammography, colorectal cancer screening, BMI screening and follow-up, screening unhealthy alcohol use, tobacco screening use and cessation intervention)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Coronary Artery Bypass Graft	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Perioperative Care	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Back pain	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Coronary Artery Disease	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Heart Failure	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Community-Acquired Pneumonia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
NCQA Recognition program certification	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Patient experience survey data (e.g., A-CAHPS)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Mortality or complication rates where applicable	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Efficiency (resource use not unit cost)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pharmacy management (e.g. generic use rate, formulary compliance)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Medication Safety	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Health IT adoption/use	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

3.5.3 PPO VERSION OF ABOVE

3.5.4 This and questions 3.5.7 and 3.7.2 define the characteristics of the Payment Reform Environment of the CPR Scorecard (Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members) for all primary care and specialty OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) and replaces **3.5.3 and 3.5.4 from eValue8 2012.** ***The corresponding question for hospital***

services is 3.7.2. THE SUM of the Number in Row 1 column 1 for outpatient and hospital services (3.5.4 and 3.7.2) should EQUAL ROW 5 in Question 1.5.3 above.

Please count OB-GYNs as specialty care physicians.

NOTE: This question asks about total $ paid in **calendar year (CY) 2012**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2012, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment questions (1.5.3, 3.4.2, 3.5.4, 3.5.7, 3.5.8, 3.7.2, 3.7.5 and 3.7.6) for CY 2012 should reflect the adjusted reporting period.**

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial members, not including prescription drug costs.

- Commercial includes both self-funded and fully-insured business.

Identify the dominant payment reform mechanism for a given payment reform program.

NOTE: Plan should report ALL dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.

	ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	**ALL Providers for Outpatient Services** (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) **Total $ Paid in Calendar Year (CY) 2012 or most current 12 months (Estimate breakout of amount in this column into percentage by contracted entity paid in next 3 columns)**	**Primary Care physicians paid under listed payment category below** Estimated ***Percentage of dollar amount listed in column 1 for each row***	**Specialists (including Ob-GYNs) paid under listed payment category below** Estimated ***Percentage of dollar amount listed in column 1 for each row***	**Contracted entities (e.g., ACOs/PCMH/ Medical Groups/IPAs) paid under listed payment category below** Estimated ***Percentage of dollar amount listed in column 1 for each row***	***This column activated only if there is % listed in column 4 (preceding column) Please select which contracted entities are paid***	**Autocalculated percent based on responses in column 1.**
1	Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE)	*Decimal.* From 0 to 100000000. N/A OK.				*Multiple options 1. ACO 2. PCMH 3. Medical Groups/IPAs*	*Autocalculated Percent This cell = 100% Denominator*
2	Provide the total dollars paid to providers through traditional						*Autocalculated Percent*

	FFS payments in CY 2012 or most recent 12 months						
3	Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2012 or most recent 12 months						*Autocalculated Percent*
4	Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2012 or most recent 12 months						*Autocalculated Percent*
5	Provide the total dollars paid to providers through fully capitated programs without quality in CY 2012 or most recent 12 months						*Autocalculated Percent*
6	**Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2012 for primary care and specialty outpatient services** (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) [Sum of Rows 2, 3 4 and 5]	*[AutoSum rows 2, 3, 4 and 5] Decimal.* From 0 to 100000000) N/A OK					***Autocalculated Percent of total dollars paid through traditional payment methods in the past year.***
7	Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2012 or most recent 12 months						*Autocalculated Percent*
8	Provide the total dollars paid to providers through FFS-based shared-savings programs with quality of care components in CY						*Autocalculated Percent*

	2012 or most recent 12 months						
9	Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality of care components CY 2012 or most recent 12 months.						*Autocalculated Percent*
10	Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2012 or most recent 12 months						*Autocalculated Percent*
11	Provide the total dollars paid to providers through fully capitated payment with quality of care components (sometimes also referred to as global payment) in CY 2012 or most recent 12 months.						*Autocalculated Percent*
12	Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2012 or most recent 12 months						*Autocalculated Percent*
13	Provide the total dollars paid to providers through bundled payment programs with quality of care components CY 2012 or most recent 12 months						*Autocalculated Percent*
14	Provide the total dollars paid for FFS-based non-visit functions. in CY 2012 or most recent 12 months.						*Autocalculated Percent*
15	Provide the total dollars paid for non-FFS-based non-visit functions. in CY 2012						*Autocalculated Percent*

	or most recent 12 months.						
16	Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***						*Autocalculated Percent*
17	***Total dollars paid to payment reform programs based on FFS. AUTOSUM ROWS 8, 10 and 14***						*Autocalculated Percent*
18	***Total dollars paid to payment reform programs NOT based on FFS. AUTOSUM ROWS 7, 9, 11-13, 15 and 16***						*Autocalculated Percent*

3.5.5. On an aggregate basis for the plan's book of business in the market of your response to the question above, indicate the relative weighting or allocation of the Plan's financial incentives for outpatient services (no associated hospital charges), and which payment approaches, if any, the health plan is using currently to tie payment to performance. If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00% within each column. Enter 0.00% if incentives not used.

		Estimate of Allocation of Incentive payments	**Product where incentive available**	**Type of Payment Approach**	**Description of other**
1	**Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)**	*Percent.*	*Single, Pull-down list.* 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	*Multi, Checkboxes.* (DM:18687556) *Multi, Checkboxes.* 1. Shared-risk (other than bundled payment) and/or gainsharing with quality 2. FFS-based Shared-savings with quality 3. Non-FFS-based Shared-savings with quality 4. FFS plus pay for performance 5. Full capitation with quality 6. Partial of condition-specific capitation with quality 7. Bundled payment with quality 8. FFS-based non-visit functions 9 Non-FFS-based non-visit functions 10. Non-payment policy for specific services associated with healthcare acquired conditions (HACs) also known as hospital-acquired conditions that were preventable or services that were unnecessary. 11: Inclusion in high performance/tiered/narrow networks 12. Other describe in next column	*65 words.*
2	**Achievement (relative to target or peers) of Clinical**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

	outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control)				
3	**Improvement over time of NQF-endorsed Outcomes and/or Process measures**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
4	**PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
5	**Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
6	**Longitudinal efficiency relative to target or peers**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
7	**Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
8	**Patient experience**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
9	**Health IT adoption or use**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
10	**Financial results**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
11	**Utilization results**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
12	**Pharmacy management**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
13	**Other**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
14	**TOTAL**	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

3.5.6 If the Plan differentiates its contracted physicians via tiered networks or other plan design that provide financial incentives to "steer" consumers to a subset of higher

performing providers, please complete the following table for total commercial book of business in market of response

If plan has 40 specialties and only 21 of those 40 are eligible for tiered networks, plan should provide the number of physicians in the 21 specialties eligible to be tiered rather than number of physicians in the 40 specialties.

	Primary care	**Specialty care**
Tiered networks, PCMH or ACOs not used	*Multi, Checkboxes - optional.* 1: Not used	*Multi, Checkboxes - optional.* 1: Not used
Number of physicians in full product network	*Decimal.* From 0 to 10000000000. N/A OK.	*Decimal.* From 0 to 10000000000000. N/A OK.
Number of physicians in preferred tier/narrow network(exclude those in PCMHs and ACOs)	AS ABOVE	AS ABOVE
Percent of network physicians in preferred tier/narrow network	AS ABOVE	AS ABOVE
Number of physicians in PCMH only (exclude those in ACOs)	AS ABOVE	AS ABOVE
Percent of network physicians in PCMH	AS ABOVE	AS ABOVE
Number of physicians in ACOs	AS ABOVE	AS ABOVE
Percent of network physicians in ACOs	*For comparison.* N/A%	*For comparison.* N/A%
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (most recent 12 months)	*Percent.* From 0 to 100. N/A OK.	*Percent.* From 0 to 100. N/A OK.
Percent of total physician payments made to physicians in the preferred tier (not in PCMH nor ACOs) (prior 12 months)	AS ABOVE	AS ABOVE
Percent of total physician payments made to PCMHs (not to those in ACOs) (most recent 12 months)	AS ABOVE	AS ABOVE
Percent of total physician payments made to physicians in the ACO (most recent 12 months)	AS ABOVE	AS ABOVE
Design incentives - HMO	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable	*Multi, Checkboxes.* 1: Differential copay, 2: Differential coinsurance, 3: Differential deductible, 4: Lower premium (narrow network), 5: Not applicable
Design incentives - PPO	AS ABOVE	AS ABOVE
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing physicians in calendar year 2012. This	*100 words*	*100 words*

could include (1) reduction in costs, (2) change in amount paid to higher performing physicians or (3) change in percent of membership using higher performing physicians		

3.5.7 For some of the information provided in 3.5.4 above, please estimate the break out as percent for primary care services and specialty services irrespective of entity that received the payment. If a specialty physician was paid for primary care services, payment $ should be counted as primary care services

	OUTPATIENT SERVICES	**ALL Providers for Outpatient Services** **Total $ Paid in Calendar Year (CY) 2012 or most current 12 months**	**Estimate of Percent of dollars paid FOR PRIMARY CARE OUTPATIENT SERVICES** ***Percent of dollar amount listed in column 1 for each row***	**Estimate of Percent of dollars paid FOR SPECIALTY OUTPATIENT SERVICES** ***Percent of dollar amount listed in column 1 for each row***
1	Total IN-NETWORK dollars paid for to Providers for ALL commercial members FOR ALL OUTPATIENT SERVICES (i.e., services for which there is NO ASSOCIATED HOSPITAL CHARGE) **[autopopulated from row 1 column 1 in 3.5.4]**	AUTOPOP FROM R1C1 FROM 3.5.4		
2	**Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2012 for outpatient services**	AUTOPOP FROM R6C1 FROM 3.5.4		
3	***Total dollars paid to payment reform programs based on FFS.***	AUTOPOP FROM R17C1 FROM 3.5.4		
4	***Total dollars paid to payment reform programs NOT based on FFS.***	AUTOPOP FROM R18C1 FROM 3.5.4		

3.5.8 Payment Reform Penetration - Plan Members: FOR those providers that participated in a payment reform contract in CY 2012 (or the time period used by respondent for the previous questions) provide an estimate of the percent of commercial, in-network plan members attributed to those providers. Attribution refers to a statistical or administrative methodology that aligns a patient population to a provider for the purposes of calculating health care costs/savings or quality of care scores for that population. "Attributed" patients can include those who choose to enroll in, or do not opt-out-of, an ACO or PCMH. For the purposes of the Scorecard, Attribution is for Commercial (self-funded and fully-insured) lives only. It does not include Medicare Advantage or Medicaid beneficiaries. If the Bidder is primarily a Medi-Cal Managed Care organization, please respond based on that population.

OUTPATIENT SERVICES	Statewide Response	Autocalc Percent	National Response	Autocalc Percent
Total number of commercial, in-network health plan members attributed to a provider with a payment reform program contract	*Numerator*	*Autocalc Percent*	*Numerator*	*Autocalc Percent*
Enrollment of TOTAL commercial enrollment		100%		100%

3.6 Hospital Performance Measurement and Reporting

Additional information not addressed elsewhere within this section can be provided in Section 3.9.

3.6.1 Provide an actual, blinded sample report or screen shot illustrating hospital performance comparative public reporting information indicated in the question below as Provider 3. Data contained in these reports must be hospital-specific and reflect the feedback elements identified in question (s) below. If the information comes from a vendor or public website and the Plan does not directly communicate the results to the hospitals, the Plan must demonstrate the process followed by the source to share the information (results and methodology) with the hospitals. Note that links to public websites do not qualify.

3.6.2 For the plan's commercial book of business, indicate if Public reports comparing HOSPITAL quality performance are available and publicly reported for any of the following categories of Measure Groups. Check all that apply. Scores on all-payer data for most hospitals on many of these measures can be viewed at: http://www.medicare.gov/hospitalcompare/search.aspx

Additional information on the measures is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html?redirect=/HospitalQualityInits/08_HospitalRHQDAPU.asp

The Agency for Healthcare Research and Quality Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data. The QIs can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time.

The current AHRQ QI modules represent various aspects of quality:

- Prevention Quality Indicators identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care. Prevention Quality Indicators can be found at http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx. (first released November 2000, last updated August 2011).

- Inpatient Quality Indicators reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures. Inpatient Quality Indicators can be found

at http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx. (first released May 2002, last updated August 2011)

- Patient Safety Indicators reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events. Patient Safety Indicators can be found at http://www.qualityindicators.ahrq.gov/Modules/psi_overview.aspx. (first released March 2003, last updated August 2011)

Information on impact of early scheduled deliveries and rates by state can be found at: http://www.leapfroggroup.org/news/leapfrog_news/4788210 and

http://www.leapfroggroup.org/tooearlydeliveries#State

Use of measures in a vendor hospital reporting product qualifies as "used for comparative PUBLIC reporting" provided that the measurement and ranking methodology is fully transparent

Numerator: the number of hospitals for which performance information is able to be calculated and displayed based on threshold of reliability (not just those informed about reporting nor those that say no data available)

Denominator: all hospitals in network

Efficiency is defined as the cost and quantity of services (i.e., total resources used) for the episode of care. For additional information, see "Measuring Provider Efficiency Version 1.0" available at: http://www.leapfroggroup.org/media/file/MeasuringProviderEfficiencyVersion1_12-31-2004.pdf and Hospital Cost Efficiency Measurement: Methodological Approaches at http://www.pbgh.org/storage/documents/reports/PBGHHospEfficiencyMeas_01-2006_22p.pdf

	% total contracted HOSPITALS INCLUDED IN PUBLIC REPORTING in market	Description of Other
HQA		
ACUTE MYOCARDIAL INFARCTION (AMI)	*Percent.* From 0 to 100. N/A OK.	
HEART FAILURE (HF)	AS ABOVE	AS ABOVE
PNEUMONIA (PNE)	AS ABOVE	AS ABOVE
SURGICAL INFECTION PREVENTION (SIP)	AS ABOVE	AS ABOVE
Surgical Care Improvement Project (SCIP)	AS ABOVE	AS ABOVE
PATIENT EXPERIENCE/H-CAHPS	AS ABOVE	AS ABOVE
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/leapfrog_safety_practices		
Adoption of CPOE	*Percent.* From 0 to 100. N/A OK.	
Management of Patients in ICU	AS ABOVE	
Evidence-Based Hospital referral indicators	AS ABOVE	

Adoption of NQF endorsed Safe Practices	AS ABOVE	
Maternity – pre 39 week elective inductions and/or elective C-section rates	AS ABOVE	
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*		
Inpatient quality indicators http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx	*Percent.* From 0 to 100. N/A OK.	
Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	AS ABOVE	
Prevention quality indicators http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx	AS ABOVE	
OTHER MEASURES		
HACs – healthcare acquired conditions also known as hospital acquired conditions (e.g., Surgical site infection following coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	*Percent.* From 0 to 100. N/A OK.	
SREs (serious reportable events) that are not HACs (e.g., surgery on the wrong body part or wrong patient) http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx	AS ABOVE	
Readmissions	AS ABOVE	
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	AS ABOVE	
ICU Mortality	AS ABOVE	
HIT adoption/use	AS ABOVE	
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	AS ABOVE	
Other standard measures endorsed by National Quality Forum (describe):	AS ABOVE	*200 words.*

3.6.3 For commercial book of business, provide the requested information on the Plans in-network general acute care hospitals in the geographic region of this RFI response based on reports to the http://www.leapfroggroup.org/ in 2011 and 2012. Multi-market plans should provide their national response in the column "For multimarket plans, and also indicate 2011 national percentages." May be revised to include Hospital Safety Score

The new 2012 "Leapfrog's Health Plan Performance Dashboard," (LHRP) shows what percentage of a plan's admissions have been at hospitals that report to Leapfrog and what percentage of their admission use hospitals that score in the highest "quadrant" based on both their LHRP quality and resource use scores http://www.leapfroggroup.org/about_leapfrog/other_initiatives/HPUG

For 2011 data, plans should use what they submitted last year. Plans who did not respond last year should select the NA box.

Additionally, the link below shows how all of the measures are displayed

http://www.leapfroggroup.org/cp?frmbmd=cp_listings&find_by=city&city=boston&state=MA&cols=oa

	2012	For multimarket plans, also indicate 2012 national percentages	2011
Percent of contracted hospitals reporting in this region	*Percent.* From 0 to 100. N/A OK.	*Percent.* From 0 to 100. N/A OK.	*Percent.* N/A OK.
Percent of Plan admissions to hospitals reporting to Leapfrog	AS ABOVE	AS ABOVE	AS ABOVE
Leapfrog Performance Dashboard % admissions in Quadrant I	AS ABOVE	AS ABOVE	AS ABOVE
Leapfrog Performance Dashboard % admissions in Quadrant III	AS ABOVE	AS ABOVE	AS ABOVE

3.6.4 (3.6.8) Please indicate the scope AND REACH of the policy to address serious reportable events or healthcare acquired conditions (HACS) also known as hospital-acquired conditions based on the following categories of services. Policy must be in place as of February 28, 2013. Leapfrog Never Event policy can be found at: http://www.leapfroggroup.org/56440/leapfrog_hospital_survey_copy/never_events

	Response	% contracted Hospitals where plan has implemented this POLICY as of 2/28/2013
Foreign object retained after surgery	*Single, Pull-down list.* 1: Plan has implemented Leapfrog Never Event Policy, 2: Plan has implemented a non-payment policy, 3: Plan does not have a policy/POA not tracked	*Percent.* From 0 to 100. N/A OK.
Air embolism	AS ABOVE	AS ABOVE
Blood incompatibility	AS ABOVE	AS ABOVE
Stage III and IV pressure ulcers	AS ABOVE	AS ABOVE
Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)	AS ABOVE	AS ABOVE
Catheter-Associated Urinary Tract Infection (UTI)	AS ABOVE	AS ABOVE
Vascular Catheter-Associate Infection	AS ABOVE	AS ABOVE
Manifestations of Poor Glycemic Control	AS ABOVE	AS ABOVE
Surgical Site Infection following Coronary Artery Bypass Graft (CABG) --Mediastinitis	AS ABOVE	AS ABOVE

Surgical Site Infection Following Certain Orthopedic Procedures	AS ABOVE	AS ABOVE
Surgical Site Infection Following Bariatric Surgery for Obesity	AS ABOVE	AS ABOVE
Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures	AS ABOVE	AS ABOVE

3.6.5 (3.6.9) For total commercial book of business, if the Plan does not pay for Serious Reportable Events (SRE) or Healthcare Acquired Conditions (HACs) also known as hospital-acquired conditions, indicate if the policy applies to the following types of reimbursement. For hospital contracts where the payment is not DRG-based, briefly describe in the Detail box below the mechanisms the Plan uses to administer non-payment policies? Also discuss how payment and member out-of-pocket liability is handled if the follow-up care or corrective surgery occurs at a different facility than where the SRE occurred.

	Insured Program	**Self-Funded Program**
% of charges	*Multi, Checkboxes.* 1: Normal contracted payment applies, 2: Proportional reduction of total contractual allowance, 3: Reduced patient out-of-pocket payment, 4: Cost excluded from employers' claims experience, 5: Other (describe in Detail below)	*Multi, Checkboxes.* 1: Normal contracted payment applies, 2: Proportional reduction of total contractual allowance, 3: Reduced patient out-of-pocket payment, 4: Cost excluded from employers' claims experience, 5: Other (describe in Detail below)
Capitation	AS ABOVE	AS ABOVE
Case Rates	AS ABOVE	AS ABOVE
Per Diem	AS ABOVE	AS ABOVE
DRG	AS ABOVE	AS ABOVE

3.6.6 (3.6.11) Reducing readmissions is an area of great interest to purchasers and payers as it impacts participant/member health and reduces costs in the system. In 2011, NCQA introduced the Plan All Cause Readmissions (PCR) measure which is the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 years of age and older. Please refer to the HEDIS 2011 Technical Specifications for specifications on reporting on this measure.

In the table below, please **review** the following information based on plan HMO submission to NCQA.

This answer may be auto-populated.

Age /	Observed Readmissions	Average Adjusted	Observed to Expected Ratio (Observed

Sex	(Num/Denominator)	Probability	Readmissions/Average Adjusted Probability)
18-44 Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
45-54 Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
55-64 Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
65-74 Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
75-84 Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
85+ Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	N/A
Total Total	*Percent.* From -5 to 100.	*Decimal.* From 0 to 1.	*Decimal.*

3.6.7 (3.6.12) PPO VERSION OF ABOVE

3.7 (3.8) Hospital Value Differentiation and Payment Rewards

Additional information not addressed elsewhere within this section can be provided in Section 3.9.

The following questions have been added to update and simplify existing questions regarding Provider Measurement and Rewards: 1.5.3, 3.5.1, 3.5.4, 3.5.7, 3.5.8, 3.7.1, 3.7.2, 3.7.6. They were developed in collaboration with Catalyst for Payment Reform. CPR has received grants from The Commonwealth Fund and the California HealthCare Foundation (CHCF) to support the development and implementation of both a National Compendium on Payment Reform and a National Scorecard on Payment Reform from the responses in questions. Information on the National Scorecard and Compendium can be found at http://catalyzepaymentreform.org/National_Scorecard.html

The CPR California Payment Reform Scorecard will report an aggregate result, e.g. "In 2012, x% of total in-network dollars were paid out as payment reform." - no plans will be identified.

The description of the payment reform programs in 3.5.1 and 3.7.1 will be reported publicly as part of CPR's Compendium for Payment Reform. Plans can opt out of having their program information reported publicly

3.7.1 (3.8.1) Purchasers are under significant pressure to address the dual goals of ensuring employees access to quality care and controlling health care costs. While it will take some time to develop, implement and evaluate new forms of payment and the corresponding operational systems, performance measurement, etc., there are immediate opportunities to improve value under the current payment systems.

These opportunities might include strategies that better manage health care costs by aligning financial incentives to reduce waste and improve the quality and efficiency of care. Keeping in mind that financial incentives can be positive (e.g. bonus payment) or negative (e.g. reduced payment for failure of performance), the current fiscal environment makes it

important to think about financial incentives that are not just cost plus, but instead help to bend the cost curve. Examples of these immediate strategies could include: non-payment for failure to perform/deliver outcomes, reduced payment for avoidable readmissions, narrow/tiered performance-based networks and reference pricing, among others.

Describe below any current payment approaches for **HOSPITAL services** that align financial incentives with reducing waste and/or improving quality or efficiency. ***Please refer to response in question 3.7.2***. If there is more than one payment reform program involving outpatient services, please provide in the additional columns.

If plan does not have any programs in market of response, please provide information on a program in the closest market to market of response, and also provide information on any programs you plan to implement in market of response within the next 6 months.

In addition to being summarized for site visits, answers to this question will be also used to help create the Catalyst for Payment Reform's (CPR) National Compendium on Payment Reform, which will be an online, searchable, sortable catalogue of all payment reform initiatives across the country. The National Compendium on Payment Reform will be a publicly available valuable resource for plans and employers to highlight innovative health plan or program entity programs. If you do not want this information to be used in the Compendium, please opt-out by checking the box in the last response row.

This question replaces 3.6.1 and section 3.10 from eValue8 2012.

	Program 1	Other markets/details for Program 1	Program 2	Other markets/details for Program 2
Name of Payment Reform Program and Name and contact details (email and phone) of contact person who can answer questions about program being described	*65 words.*	N/A	*65 words.*	N/A
Geography of named payment reform program (Ctrl-Click for multiple states)	*Single, Radio group.* 1: Not in this market (Identify market in column to the right), 2: In this market and other markets (Identify market(s) in column to the right), 3: Only in this market	*Multi, List box.* 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, 6: Colorado, 7: Connecticut, 8: Delaware, 9: Florida, 10: Georgia, 11: Hawaii, 12: Idaho, 13: Illinois, 14: Indiana, 15: Iowa, 16: Kansas,	*Single, Radio group.* 1: Not in this market (Identify market in column to the right), 2: Only in this market, 3: In this market and other markets (Identify markets in column to the right)	*Multi, List box.* 1: Alabama, 2: Alaska, 3: Arizona, 4: Arkansas, 5: California, 6: Colorado, 7: Connecticut, 8: Delaware, 9: Florida, 10: Georgia, 11: Hawaii, 12: Idaho, 13: Illinois, 14: Indiana, 15: Iowa, 16: Kansas,

		17: Kentucky, 18: Louisiana, 19: Maine, 20: Maryland, 21: Massachusetts, 22: Michigan, 23: Minnesota, 24: Mississippi, 25: Missouri, 26: Montana, 27: Nebraska, 28: Nevada, 29: New Hampshire, 30: New Jersey, 31: New Mexico, 32: New York, 33: North Carolina, 34: North Dakota, 35: Ohio, 36: Oklahoma, 37: Oregon, 38: Pennsylvania, 39: Rhode Island, 40: South Carolina, 41: South Dakota, 42: Tennessee, 43: Texas, 44: Utah, 45: Vermont, 46: Virginia, 47: Washington State, 48: Washington D.C., 49: West Virginia, 50: Wisconsin, 51: Wyoming		17: Kentucky, 18: Louisiana, 19: Maine, 20: Maryland, 21: Massachusetts, 22: Michigan, 23: Minnesota, 24: Mississippi, 25: Missouri, 26: Montana, 27: Nebraska, 28: Nevada, 29: New Hampshire, 30: New Jersey, 31: New Mexico, 32: New York, 33: North Carolina, 34: North Dakota, 35: Ohio, 36: Oklahoma, 37: Oregon, 38: Pennsylvania, 39: Rhode Island, 40: South Carolina, 41: South Dakota, 42: Tennessee, 43: Texas, 44: Utah, 45: Vermont, 46: Virginia, 47: Washington State, 48: Washington D.C., 49: West Virginia, 50: Wisconsin, 51: Wyoming
Summary/Brief description of Program (500 words)	*500 words.*	N/A	*500 words.*	N/A
Identify the line(s) of business for which this program is available?	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*	*Multi, Checkboxes.* 1: Self-insured commercial, 2: Fully-insured commercial, 3: Medicare, 4: Medicaid, 5: Other – please describe in next column	*50 words.*
What is current stage of implementation? Provide date of implementation in detail column	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the minute.*	*Single, Radio group.* 1: Planning mode, 2: Pilot mode (e.g. only available for a subset of members and/or providers), 3: Expansion mode (e.g. passed initial pilot stage and broadening reach), 4: Full implementation (e.g. available to all intended/applicable providers and members)	*To the minute.*

To which payment reform model does your program most closely align?	*Single, Radio group.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	*65 words.*	*Single, Radio group.* 1: Shared-risk (other than bundled payment) and/or gainsharing with quality, 2: FFS-based Shared-savings with quality, 3: Non-FFS-based Shared-savings with quality, 4: FFS plus pay for performance, 5: Full capitation with quality, 6: Partial or condition-specific capitation with quality, 7: Bundled payment with quality, 8: FFS-based non-visit functions, 9: Non-FFS-based non-visit functions, 10: Non-payment for specific services associated with hospital-acquired conditions that were preventable or services that were unnecessary, 11: Other non-FFS based payment reform models (provide details in next column)	*65 words.*
Which base payment methodology does your program use?	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled/episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8: Other - (provide details in next column)	*100 words.*	*Single, Radio group.* 1: Capitation without quality, 2: Salary, 3: Bundled/episode-based payment without quality, 4: FFS (includes discounted fees, fixed fees, indexed fees), 5: Per diem, 6: DRG, 7: Percent of charges, 8 Other - (provide details in next column)	*100 words.*
What types of providers are participating in your program?	*Multi, Checkboxes.* 1: Primary care physicians who are not hospital-based, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) who are not hospital-based – describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*100 words.*	*Multi, Checkboxes.* 1: Primary care physicians who are not hospital-based, 2: Physician Specialists (e.g., Oncology, Cardiology, etc.) who are not hospital-based – describe in next column, 3: RNs/NP and other non-physician providers, 4: Hospital inpatient, 5: Other - (provide details in next column)	*100 words.*
If you have a payment reform model that includes policies	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions,	*65 words.*	*Multi, Checkboxes.* 1: N/A, 2: Ambulatory care sensitive admissions,	*65 words.*

on non-payment for specific services associated with complications that were preventable or services that were unnecessary, for which outcomes are these policies in place?	3: Healthcare/hospital-acquired conditions(HACs), 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)		3: Healthcare/hospital-acquired conditions (HACs), 4: Preventable Admissions, 5: Serious Reportable Events (SREs) that are not HACs, 6: Never Events, 7: Early elective induction or cesarean, 8: Other - (provide details in next column)	
Which of the following sets of performance measures does your program use?	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	*100 words.*	*Multi, Checkboxes.* 1: Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings), 2: Achievement (relative to target or peers) of Clinical outcomes goals(e.g., readmission rate, mortality rate, A1c, cholesterol values under control), 3: Improvement over time of NQF-endorsed Outcomes and/or Process measures, 4: PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues), 5: Appropriate maternity care, 6: Longitudinal efficiency relative to target or peers, 7: Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel), 8: Patient experience, 9: Health IT adoption or use, 10: Financial results, 11: Utilization results, 12: Pharmacy management, 13: Other - (provide details in next column)	*100 words.*
Indicate the type(s) of benefit and/or provider network design features that	*Multi, Checkboxes.* 1: Mandatory use of Centers of Excellence (COE) or higher performing providers,	*100 words.*	*Multi, Checkboxes.* 1: Use of Centers of Excellence (COE or higher performing providers required for coverage,	*100 words.*

create member incentives or disincentives to support the payment reform program.	2: Financial incentives (lower premium, waived/lower co-pays) for members to use COE/higher performance providers, 3: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 4: Use of tiered/high performance or narrow networks, 5: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 6: No active steerage, 7: No COE or high performing providers program, 8: Other (please describe)		2: Financial disincentives for members to use non-COE or lower performing providers (e.g., higher co-pays, etc.), 3: Use of tiered/high performance or narrow networks, 4: Objective information (e.g., performance measure results) provided on COEs to members, providing evidence of higher-quality care rendered by these providers, 5: No active steerage, 6: No COE or high performing providers program, 7: Other (please describe)	
For this payment reform program, do you make information transparent such as performance reports on quality, cost and/or efficiency measures at the provider level?	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*100 words.*	*Multi, Checkboxes.* 1: We report to the general public, 2: We report to our network providers (e.g. hospitals and physicians), 3: We report to patients of our network providers, 4: We do not report performance on quality measures, 5: We report to state or community data collection processes such as all-payer claims databases (APCDs), or AF4Q sites, 6: Other (please describe)	*100 words.*
Describe evaluation and results for program	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*500 words.*	*Multi, Checkboxes.* 1: Program not evaluated yet, 2: Program evaluation by external third party, 3: Program evaluation by insurer, 4: Evaluation method used pre/post, 5: Evaluation method used matched control group, 6: Evaluation method used randomized control trial, 7: Other evaluation methodology was used (provide details in column to the right)	*500 words.*
Do not include this information in the National	*Multi, Checkboxes - optional.*			

Compendium on Payment Reform	1: X			

3.7.2 (3.8.2) This and questions 3.5.4 and 3.5.7define the characteristics of the Payment Reform Environment of the CPR Scorecard (Note: Metrics below apply only to IN-NETWORK dollars paid for ALL commercial members) for HOSPITAL SERVICES **and replaces 3.8.1 and 3.8.2 from eValue8 2012.** ***The corresponding question for outpatient services is 3.5.4. The SUM of the Number in Row 1 column 1 for outpatient and hospital services (3.5.4 and 3.7.2) should EQUAL ROW 5 in Question 1.5.3 above.***

NOTE: This question asks about total dollars ($) paid in **calendar year (CY) 2012**. **If, due to timing of payment, sufficient information is not available to answer the questions based on the requested reporting period of CY 2012, Plans may elect to report on the most recent 12 months with sufficient information and note time period in detail box below. If this election is made, ALL answers on CPR payment questions (1.5.3, 3.4.2, 3.5.4, 3.5.7, 3.5.8, 3.7.2, 3.7.5 and 3.7.6) for CY 2012 should reflect the adjusted reporting period.**

- Unless indicated otherwise, questions apply to health plans' dollars paid for in-network, commercial members, not including prescription drug costs.

- Commercial includes both self-funded and fully-insured business.

*For the "Characteristics of the Payment Reform Environment" domain questions, identify the **dominant** payment reform mechanism for a given payment reform program.*

NOTE: Plan should report ALL dollars paid through contracts containing this type of payment program, not only the dollars paid out as an incentive.

	HOSPITAL SERVICES	**ALL Providers for HOSPITAL Services** **Total $ Paid in Calendar Year (CY) 2012 or most current Estimate breakout of amount in this column into percentage by contracted entity paid in next 2 columns**	**HOSPITALS paid under listed payment category below** Estimated ***Percentage of dollar amount listed in column 1 for each row***	**Contracted entities (e.g., ACOs/PCMH/Medical Groups/IPAs) paid under listed payment category below** Estimated ***Percentage of dollar amount listed in column 1 for each row***	***This column activated only if there is % listed in column 3*** ***Please select which contracted entities are paid in column 3***	**Autocalculated percent based on responses in column 1.**

1	Total IN-NETWORK dollars paid for to Providers for ALL commercial members for HOSPITAL SERVICES	*Decimal.* From 0 to 100000000. N/A OK.			*Multiple options* *1. ACO* *2. PCMH* *3. Medical Groups/IPAs* *4. Primary Care* *5. Specialists*	*Autocalculated Percent* *This cell = 100%* *Denominator*
2	Provide the total dollars paid to providers through traditional FFS payments in CY 2012 or most recent 12 months	*Decimal.* From 0 to 100000000) N/A OK.				*Autocalculated Percent*
3	Provide the total dollars paid to providers through bundled payment programs without quality components in CY 2012 or most recent 12 months					*Autocalculated Percent*
4	Provide the total dollars paid to providers through partial or condition-specific capitation programs without quality components in CY 2012 or most recent 12 months					*Autocalculated Percent*
5	Provide the total dollars paid to providers through fully capitated programs without quality in CY 2012 or most recent 12 months					*Autocalculated Percent*
6	**Subtotal: Dollars paid out under the status quo: total dollars paid through traditional payment methods in CY 2012 for outpatient services** [Sum of Rows 2, 3 4 and 5]	*[AutoSum rows 2, 3, 4 and 5]* *Decimal.* From 0 to 100000000) N/A OK				***Autocalculated Percent of total dollars paid through traditional payment methods in the past year.***
7	Provide the total dollars paid to providers through shared-risk programs with quality components in CY 2012 or most recent 12 months	*Decimal.* From 0 to 100000000) N/A OK				*Autocalculated Percent*
8	Provide the total dollars paid to providers through FFS-based shared-savings programs with quality of care components in CY 2012 or most recent 12 months	*Decimal.* From 0 to 100000000) N/A OK				*Autocalculated Percent*

9	Provide the total dollars paid to providers through non-FFS-based shared-savings programs with quality of care components CY 2012 or most recent 12 months.					*Autocalculated Percent*
10	Provide the total dollars paid to providers through FFS base payments plus pay-for-performance (P4P) programs CY 2012 or most recent 12 months					*Autocalculated Percent*
11	Provide the total dollars paid to providers through fully capitated payment with quality of care components (sometimes also referred to as global payment) in CY 2012 or most recent 12 months.					*Autocalculated Percent*
12	Provide the total dollars paid to providers through partial or condition-specific capitation programs with quality components in CY 2012 or most recent 12 months					*Autocalculated Percent*
13	Provide the total dollars paid to providers through bundled payment programs with quality of care components CY 2012 or most recent 12 months					*Autocalculated Percent*
14	Provide the total dollars paid for FFS-based non-visit functions. in CY 2012 or most recent 12 months.					*Autocalculated Percent*
15	Provide the total dollars paid for non-FFS-based non-visit functions. in CY 2012 or most recent 12 months.					*Autocalculated Percent*
16	Provide the total dollars paid to providers whose contract contains other types of performance-based incentive program not captured above ***and NOT based on FFS***					*Autocalculated Percent*

17	***Total dollars paid to payment reform programs based on FFS.*** ***AUTOSUM ROWS 8, 10 and 14***					*Autocalculated Percent of total dollars paid based on FFS (including traditional and payment reform).*
18	***Total dollars paid to payment reform programs NOT based on FFS.*** ***AUTOSUM ROWS 7, 9, 11-13, 15 and 16***					*Autocalculated Percent of total dollars paid through "payment reform programs" including bundled payment, shared-risk, shared savings, bundled payments, pay for performance, atypical payments (e.g. for care coordination), global payment/capitation with quality components, and other models*

3.7.3 (3.8.3) Please review your responses to questions 3.7.2 above. On an aggregate basis for the plan's TOTAL COMMERCIAL book of business in the market of your response, indicate the relative weighting or allocation of the Plan's financial incentives for hospital services, and which payment approaches, if any, the health plan is using currently to tie payment to performance If the relative weighting varies by contract, describe the most prevalent allocation. The Plan's response should total 100.00%. Enter 0.00% if incentives not use. (This question uses same measures as in 3.5.5).

H	Hospital Services	Allocation of Incentive payments	Product where incentive available	Type of Payment Approach	Description of other
1	**Achievement (relative to target or peers) of Clinical process goals (e.g., prophylactic antibiotic administration, timeliness of medication administration, testing, screenings)**	*Percent.*	*Single, Pull-down list.* 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	*Multi, Checkboxes.* 1. Shared-risk (other than bundled payment) and/or gainsharing with quality 2. FFS-based Shared-savings with quality 3. Non-FFS-based Shared-savings with quality 4. FFS plus pay for performance 5. Full capitation with quality 6. Partial of condition-specific capitation with quality 7. Bundled payment with quality 8. FFS-based non-visit functions 9 Non-FFS-based non-visit functions 10. Non-payment policy for specific services associated with healthcare acquired conditions (HAVCs) also known as hospital-acquired conditions that were preventable or services that were unnecessary. 11. Other non-FFS based payment reform models describe in next column	*65 words.*
2	**Achievement (relative to target or peers) of Clinical outcomes goals(e.g.,**	AS ABOVE	AS ABOVE	AS ABOVE	

	readmission rate, mortality rate, A1c, cholesterol values under control)				
3	**Improvement over time of NQF-endorsed Outcomes and/or Process measures**	AS ABOVE	AS ABOVE	AS ABOVE	
4	**PATIENT SAFETY (e.g., Leapfrog, AHRQ, medication related safety issues)**	AS ABOVE	AS ABOVE	AS ABOVE	
5	**Appropriate Maternity Care (adhering to clinical guidelines which if followed, would reduce unnecessary elective interventions)**	AS ABOVE	AS ABOVE	AS ABOVE	
6	**Longitudinal efficiency relative to target or peers**	AS ABOVE	AS ABOVE	AS ABOVE	
7	**Application of specific medical home practices (e.g., intensive self management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)**	AS ABOVE	AS ABOVE	AS ABOVE	
8	**Patient experience**	AS ABOVE	AS ABOVE	AS ABOVE	
9	**Health IT adoption or use**	AS ABOVE	AS ABOVE	AS ABOVE	
10	**Financial results**	AS ABOVE	AS ABOVE	AS ABOVE	
11	**Utilization results**	AS ABOVE	AS ABOVE	AS ABOVE	
12	**Pharmacy Management**	AS ABOVE	AS ABOVE	AS ABOVE	
13	**Other**	AS ABOVE	AS ABOVE	AS ABOVE	
14	**Total**	AS ABOVE	AS ABOVE	AS ABOVE	

3.7.4 (3.8.4) For the measures used in determining financial incentives paid to PHYSICIANS AND/OR hospitals involving HOSPITAL SERVICES IN THIS MARKET, indicate payment approach, system/entities paid and the percentage of the contracted entities receive payment reward. To calculate percentage, please use unduplicated count of hospitals and physicians.

In detail box below - please note if needed any additional information about percentages provided (e.g., if payment is made for a composite set of measures - indicate which)

This is same measure set as in 3.6.2

	Product where incentive available	**System/ Entity Paid**	**Type of Payment Approach**	**Description of Other**	**% network hospitals (unduplicated) receiving reward**	**% network physicians (unduplicated) receiving reward**
HQA						
ACUTE MYOCARDIAL INFARCTION (AMI)	*Single, Radio group.* 1: HMO, 2: PPO, 3: Both HMO and PPO, 4: Not available	*Multi, Checkboxes.* 1: Hospital, 2: ACO, 3: Physician or physician group, 4: Other	*Multi, Checkboxes.* Multi, Checkboxes. 1. Shared-risk (other than bundled payment) and/or gainsharing with quality 2. FFS-based Shared-savings with quality 3. Non-FFS-based Shared-savings with quality 4. FFS plus pay for performance 5. Full capitation with quality 6. Partial of condition-specific capitation with quality 7. Bundled payment with quality 8. FFS-based non-visit functions 9 Non-FFS-based non-visit functions 10. Non-payment policy for specific services associated with healthcare acquired conditions (HAVCs) also known as hospital-acquired conditions that were preventable or services that were unnecessary. 11. Other non-FFS based payment reform models describe in next column	*200 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.
HEART FAILURE (HF)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
PNEUMONIA (PNE)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
SURGICAL INFECTION PREVENTION (SIP)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Surgical Care Improvement Project (SCIP)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
PATIENT EXPERIENCE/H-CAHPS	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
LEAPFROG Safety Practices http://www.leapfroggroup.org/56440/leapfrog_h	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

ospital_survey_copy/leapfrog_safety_practices						
Adoption of CPOE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Management of Patients in ICU	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Evidence-Based Hospital referral indicators	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Adoption of NQF-endorsed Safe Practices	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Maternity – pre 39 week elective inductions and C-section rates	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)*	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Inpatient quality indicators http://www.qualityindicators.ahrq.gov/Modules/iqi_overview.aspx	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Patient safety indicators http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Prevention quality indicators http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
OTHER MEASURES						
HACs – healthcare acquired conditions also known as hospital acquired conditions (e.g., Surgical site infection following	*Single, Radio group.* 1: HMO, 2: PPO, 3: Both HMO and PPO,	*Multi, Checkboxes.* 1: Hospital, 2: ACO, 3: Physician or physician	*Multi, Checkboxes.* 1. Shared-risk (other than bundled payment) and/or gainsharing with quality 2. FFS-based Shared-savings with quality 3. Non-FFS-based Shared-savings with quality 4. FFS plus pay for performance 5. Full capitation with quality	*200 words.*	*Percent.* N/A OK.	*Percent.* N/A OK.

coronary artery bypass graft (CABG)—mediastinitis) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html	4: Not available	group, 4: Other	6. Partial of condition-specific capitation with quality 7. Bundled payment with quality 8. FFS-based non-visit functions 9 Non-FFS-based non-visit functions 10. Non-payment policy for specific services associated with healthcare acquired conditions (HAVCs) also known as hospital-acquired conditions that were preventable or services that were unnecessary. 11. Other non-FFS based payment reform models describe in next column			
SREs that are not HACs (e.g., surgery on the wrong body part or wrong patient) www.qualityforum.org/Topics/SREs/List_of_SREs.aspx	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Readmissions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
MORTALITY MEASURES (AMI, HF and Pneumonia mortality measures)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
ICU Mortality	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
HIT adoption/use	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Efficiency (e.g., relative cost, utilization (ALOS, AD/k) Volume indicators other than Leapfrog EHR)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other standard measures endorsed by National Quality Forum (describe):	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

3.7.5 (3.8.5) For total commercial book of business, if the Plan differentiates its contracted hospitals via tiered networks or other plan design that provide financial incentives to "steer" consumers to a subset of higher performing providers, please complete the following table.

	Hospitals

Tiered networks/ACOs used	*Single, Radio group.* 1: Yes, 2: No
Number of hospitals in full product network	*Decimal.* From 0 to 10000000000.
Number of network hospitals in preferred tier/narrow network (not in ACO)	AS ABOVE
Number of network hospitals in ACOs	AS ABOVE
Percent of network hospitals in preferred tier/narrow network (not in ACO)	AUTOCALC
Percent of network hospitals in ACOs	AUTOCALC
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (most recent 12 months)	*Percent.* From 0 to 100. N/A OK.
Percent of total hospital payments made to hospitals in the preferred tier (not in ACO) (prior 12 months)	AS ABOVE
Percent of total hospital payments made to hospitals in ACOs (most recent 12 months)	AS ABOVE
Design incentives (HMO)	*Multi, Checkboxes.* 1: differential copay, 2: differential coinsurance, 3: differential deductible, 4: lower premium (narrow network), 5: none of the above
Design incentives (PPO)	AS ABOVE
Briefly describe (100 words or less) the impact and any quantitative results of plan efforts to promote member selection of higher performing hospitals) in calendar year 2012. This could include (1) reduction in costs, (2) change in amount paid to higher performing hospitals or (3) change in percent of membership using higher performing hospitals	*100 words*

3.7.6 (3.8.6) Payment Reform for High Volume/High Spend Conditions - Maternity Care (Note: Metrics below apply only to in-network dollars paid for commercial members). Please ensure your response in 5.8.7 is consistent with your response to this question.

H	Maternity Payment Reform	***Response***
1	**Provide the total dollars paid to hospitals for maternity care in Calendar Year (CY) 2012 or most current 12 months**	$ NA OK
2	**Provide the total dollars paid for maternity care to hospitals with contracts that provide incentives for adhering to clinical guidelines, which, if followed, would reduce unnecessary elective medical intervention during labor and delivery in the past year.**	$ NA OK
3	**Autocalc: Row 2/Row 1** **Percent of total maternity care dollars paid that go to hospitals with contracts that provide incentives for adhering to clinical guidelines which, if followed, would reduce unnecessary elective interventions related to unnecessary elective medical intervention during labor and delivery in the past year.**	*Percent autocalc*

3.8 (3.9) Centers of Excellence or High Performance Hospital Networks

Additional information not addressed elsewhere within this section can be provided in Section 3.9.

3.8.1 (3.9.1) For HMO, indicate how members are steered toward COE facilities. For steerage results indicate % of targeted services to designated facilities. Describe any measured quality impact such as reduced complications or improved outcomes, as well as any savings impact such as reduced length of stay.

HMO response	Selection Criteria	Steerage Results 2012	Quality and Cost Impact (2012)	Steerage Results 2011
Bariatric Surgery	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	*Percent.* N/A OK.	*Unlimited.*	*Percent.* N/A OK.
Cancer Care	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	AS ABOVE	AS ABOVE	AS ABOVE
Cardiac Care	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	AS ABOVE	AS ABOVE	AS ABOVE
Neonatal Care	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	AS ABOVE	AS ABOVE	AS ABOVE
Transplants	*Multi, Checkboxes.* 1: Mandatory use of COE, 2: Financial incentive for members to use COE, 3: Members encouraged to use COE by Plan staff or through general communications, 4: No active steerage, 5: No COE program	AS ABOVE	AS ABOVE	AS ABOVE

3.8.2 (3.9.2) PPO VERSION OF ABOVE

3.9 (3.10) Other Information

3.9.1 (3.10.1). If the plan would like to provide additional information about its approach to Provider Measurement that was not reflected in this section, provide as Provider 4. Provider 4 is provided

4 Pharmaceutical Management

4.1 Instructions

4.1.1 You may rely on the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI.

4.1.2 All attachments to this module must be labeled as "Pharmacy #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Pharmacy 1a, Pharmacy 1b, etc.

The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

4.1.3 Pharmacy Benefit Manager is abbreviated as "PBM" throughout this form. If the Plan contracts with a PBM, the Plan is strongly encouraged to work collaboratively with the PBM in the completion of this form.

4.1.4 All questions refer to the Plan's commercial membership. Membership of commercial customers that have removed pharmacy management from the Plan (carved-out) and directly contracted with a separate PBM should be excluded from all responses and calculations.

4.1.5 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been auto-populated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

4.1.6 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

4.2 Program Organization

Additional information not addressed elsewhere within this section can be provided in Section 4.6.

4.2.1 Has the Plan developed a “value-based” formulary for use by purchasers that ranks pharmaceuticals ACROSS DRUG CLASSES by clinical importance and effectiveness? (This is different from the Plan's decision process of the pharmacy and therapeutics committee to determine which drugs are placed on formulary. By this definition the Plan must have considered the relative criticality of drugs between drug classes and introduced copays or coinsurance designs that make some brand drugs available on the lowest cost tier for “essential” drug classes regardless of availability of generic and/or OTC medications to make substantial use of brand drugs necessary to accommodate member needs.). If the Plan has developed a value-based formulary as defined above, describe in the Detail text box the following: process and sources for determining its content and structure, the purchaser name(s) and the market if this is a pilot. If this was a pilot the previous year, please provide a brief update in detail box.

Single, Pull-down list.

1: Yes, and the ranking is tied to a variable copay design available in this market,
2: Yes, and the ranking is tied to a variable copay design being piloted,
3: Yes, but there is currently no link to a variable copay design,
4: An evidence-based formulary is under development,
5: No

4.3 Efficiency & Appropriateness: Generic & Appropriate Drug Use

Additional information not addressed elsewhere within this section can be provided in Section 4.6.

4.3.1 Does the Plan employ any of the following strategies (defined below) to address cost management or appropriateness of utilization?

Therapeutic class reference pricing defined as: assigning a maximum allowable cost for the lowest cost drug among therapeutically equivalent drugs. For therapeutic class MAC strategies, the member or physician group at risk, etc. would bear the cost differential of the higher priced drug, if he/she chose to ignore the lower cost recommendation.

Therapeutic Interchange: defined as substitution of therapeutically equivalent drugs at the point of service or in a subsequent refill after physician consultation.

Prior Authorization defined as a requirement that the Practitioner receive authorization from the Plan before the drug can be dispensed.

Step therapy is used in cases where there may be some patient-specific advantages to one brand drug compared to another or to a generic, and is defined as a requirement that the appropriate, usually less expensive drugs be tried first to determine efficacy before converting to a higher priced drug in the same class.

Dose Optimization defined as requiring that single dose-alternatives be used instead of multiple doses per day where single doses are possible.

Multi, Checkboxes.
1: Therapeutic Class reference Pricing,
2: Therapeutic Interchange,
3: Prior Authorization,
4: Step Therapy,
5: Dose Optimization,
6: Pill Splitting,
7: None of the above

4.3.2 For HMO, provide the Plan's aggregate generic dispensing rate (% of total prescriptions that were filled with a generic drug, regardless of whether a generic was available), excluding injectables. The Plan should report the strict definition of "generic" provided by a nationally recognized and accepted source (i.e. First DataBank or Medispan). Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round up to convert. For example, a 100 day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4). If the Plan has a policy of covering prescription and/or OTC brand drugs where the generic drug is more expensive, indicate in the “Adj Answer” row the dispensing rate adding those fills to the numerator and denominator.

HMO Response	2012 Percent for this market/state	2011 Percent for this market/state	2012 Percent for the nation	2011 Percent for the nation
Aggregate Generic Dispensing Rate	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Percent.* From 0 to 100.00. N/A OK.	*Percent.* N/A OK.
Adj Answer	*Percent.*	*Percent.*	*Percent.* N/A OK.	*Percent.* N/A OK.

4.3.3 PPO VERSION OF ABOVE

4.3.4 For the HMO, provide the requested rates as defined below. Use 30-day equivalents in calculating percentages. To determine the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round up to convert. For example, a 100 day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded up to 4).

HMO Response	Rx program in Market/State?	Market/State 2012 rate	Market/State 2011 rate	Rx program in nation?	National 2012 rate	National 2011 rate
ACE inhibitors (ACE and ACE with HCTZ)/(ACE + ARBs (angiotensin II receptor antagonists)) Include ACE and ARB drugs that are dispensed as combination drugs in the denominator	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.	*Single, Radio group.* 1: Yes, 2: No	*Percent.* From 0 to 100. N/A OK.	*Percent.* N/A OK.
(Generic PPIs +OTC PPIs / (All PPIs INCLUDING OTC PPIs)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Generic STATINS/(ALL Cholesterol lowering agents) Cholesterol lowering agents : statins (and statin combinations e.g., atoravastatin/amlodipine combination), bile acid binding resins (e.g., cholestyramine, colestipol and colesevelam), cholesterol absorption inhibitors and combinations (ezetimibe and ezetimibe/simvastatin),fibrates (fenofibrate and gemfibrozil), Niacin (vitamin B-3, nicotinic acid) and niacin/lovastatin combination. IF ezetimibe/simvastatin is counted in statin combination - DO NOT COUNT again under ezetimibe combination.	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Generic metformin/all oral anti diabetics, including all forms of glucophage	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Generic SSRIs/all SSRI antidepressants	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

4.3.5 PPO VERSION OF ABOVE

4.3.6 Review the overall rate of antibiotic utilization from HEDIS QC 2012. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	QC 2012 (HMO)
Average number of antibiotic scripts PMPY	*Decimal.*
Average days supplied per antibiotic script	*Decimal.*
Average number of scripts PMPY for antibiotics of concern	*Decimal.* From -10 to 100.
Percentage of antibiotics of concern out of all antibiotic scripts	*Percent.* From -10 to 100.

4.3.7 PPO VERSION OF ABOVE

4.4 Specialty Pharmaceuticals

Additional information not addressed elsewhere within this section can be provided in Section 4.6.

4.4.1 Purchasers have an increasing interest in the prevalence of use and cost of specialty medications and biologics. For total spend in calendar year 2012, please provide **estimates** of the percent spent on self-administered medications, and percent reimbursed through the medical benefit. Describe below the plan's (1) current strategy, activities and programs implemented to manage specialty pharmaceuticals & biologics in 2012. (2) Please outline any changes planned for 2013. (3) If plan uses a specialty vendor, please describe their strategy and provide their name.

Does plan use a specialty vendor? If yes provide name	*200 words.*
Estimate % of specialty pharmacy drug spend that is reimbursed under the medical benefit	*Percent.*
Estimate the % of specialty drug spend that is self-administered	*Percent*
Current strategy, activities or programs to manage specialty medicines and biologics	*200 words.*
Changes planned in following year	*100 words.*

4.4.2 Indicate if the Plan implemented one or more of the following programs to address specialty pharmaceuticals (SP) in 4.4.1. Check all that apply.

Program	Answer	Describe Program (and Tiering)
Use of formulary tiers or preferred/non-preferred status (if yes, please describe in last column what tier or status you typically use for the drugs listed)	*Single, Radio group.* 1: Yes, 2: No	*200 words.*
Utilization Management		
Prior authorization	*Single, Radio group.* 1: Yes, 2: No	*200 words.*
Step edits	AS ABOVE	AS ABOVE
Quantity edits/limits	AS ABOVE	AS ABOVE
Limits on off label use	AS ABOVE	AS ABOVE
Channel Management (limiting dispensing to specific providers)	AS ABOVE	AS ABOVE
Reimbursement Reductions (reimbursing physicians, PBM, pharmacies according to a fixed fee schedule)	AS ABOVE	AS ABOVE
None of the above	AS ABOVE	

4.4.3 (4.4.4) Does the Plan allow an employer the option to allow physician administered products to be delivered via the pharmacy benefit versus medical benefit? If YES, please detail below how Plan would do this for chemotherapy delivered directly by physicians.

Yes/No.

4.4.4 (4.4.5) For the listed conditions associated with SP drugs, indicate how these conditions are managed.

Condition	Management	Details (description of “other” or the main condition)
Rheumatoid Arthritis	*Multi, Checkboxes.* 1: Managed by DM/care management program if it is the sole condition, 2: Managed by DM/care management program only if a comorbidity with another condition (e.g. diabetes), (name the condition in the next column) 3: Internally Managed as part of SP program independent of the DM/care management Program, 4: Managed by SP vendor independent of the DM/care management	

	program, 5: Member compliance with SP drugs is monitored through refill claims and made available to care managers, 6: Not managed by either DM/care management or SP program 7. Integrated as part of patient centered care Other (describe in next column)	
Multiple Sclerosis	AS ABOVE	
Oncology	AS ABOVE	
Hepatitis C	AS ABOVE	
HIV	AS ABOVE	
Hemophilia	AS ABOVE	
Growth Hormone Deficiency	AS ABOVE	

4.4.5 (4.4.10) Using only the drugs identified in question 4.4.1 and their condition associations (e.g. hepatitis C), identify the cost per member per month (PMPM) for SP/biotech pharmaceuticals including acquisition, administration fees and member copayments BUT net of rebates, discounts, data fees, or other payment by the pharmaceutical manufacturer.

Drug Class	2012 PMPM Cost	2011 PMPM Cost
TNF Inhibitors	*Dollars.*	*Dollars.*
ESAs excluding dialysis medications	*Dollars.*	*Dollars.*
WBC Growth Factors	*Dollars.*	*Dollars.*
MS Drug Therapies	*Dollars.*	*Dollars.*
Hepatitis C Drug Therapies	*Dollars.*	*Dollars.*
Oral Oncolytics	*Dollars.*	*Dollars.*
Office-administered drugs	*Dollars.*	*Dollars.*
Total	*For comparison.* $0.00	*For comparison.* $0.00

4.5 Quality and Safety: Outpatient Prescribing

4.5.1 Review HEDIS scores for the indicators listed.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	HEDIS QC 2012 (HMO)	**HEDIS QC 2011 (HMO)**
Appropriate treatment for children with upper respiratory infection	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Appropriate testing for children with pharyngitis	AS ABOVE	AS ABOVE
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	AS ABOVE	AS ABOVE
Use of Appropriate Medications for People with Asthma - Total	AS ABOVE	AS ABOVE
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Digoxin	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Diuretics	AS ABOVE	AS ABOVE
Annual Monitoring for Patients on Persistent Medications - Total	AS ABOVE	AS ABOVE

4.5.2 PPO VERSION OF ABOVE

4.5.3 (4.5.5) For persons with asthma on medication therapy, purchasers expect plans to monitor and identify those who are not controlled optimally and/or not on controller therapy. Please see the attachment for the Pharmacy Quality Alliance (PQA) approved definitions to respond to question on suboptimal control and absence of controller therapy. The NDCs list attachment can be found in "Manage Documents" Driver in the Proposal Tech eRFP or
at http://pqaalliance.org/images/uploads/files/PQA%20approved%20measures.pdf

National carriers - if plan provided a national response - please note this in detail box below

Description	Rate (HMO Statewide Response)	Rate (PPO Statewide Response)
Suboptimal Control: The percentage of patients with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.	*Percent.* From 0 to 100. N/A OK.	*Percent.* From 0 to 100. N/A OK.

4.6 Other Information

4.6.1 If the Plan would like to provide additional information about the pharmacy program that was not reflected in this section, provide as Attachment Pharmacy 1.

5. Prevention and Health Promotion

5.1 Instructions

5.1.1 You may rely on the “General Background and Process directions document for background, process and response instructions that apply across the 2013 eValue8 RFI. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

5.1.2 All attachments to this module must be labeled as "Prevention #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as Prevention 1a, Prevention 1b, etc.

5.1.3 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. New last year and again for this year HMO and PPO responses are being collected in the same RFI template. Note in questions where HEDIS or CAHPS data, or plan designed performance indicators are reported; one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been auto-populated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question below in 1.1.5

5.1.4 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

5.2 Quality Improvement Strategy - Health Promotion Programs

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.2.1 For your commercial book of business, identify the programs or materials that are offered in this market to support health and wellness for all commercial members, excluding the Plan's own employees, in calendar year 2012. If programs are also available on-site, but are not offered as a standard benefit for all members, please indicate

the minimum number of health plan members required to receive the service at no additional charge.

Requirements that include the term "targeted" when referencing information or education should be consistent with threshold criteria for Information Therapy ("Ix"). Requirements for being classified as Ix include: 1. Targeted to one or more of the individual's current moments in care. 2. Be proactively provided/prescribed to the individual. 3. Support one of more of the following: informed decision making, and or, skill building and motivation for effective self-care and healthy behaviors to the moment in care, and/or patient comfort/acceptance. 4. Be tailored to an individual's specific needs and/or characteristics, including their health literacy and numeracy levels. 5. Be accurate, comprehensive, and easy to use.

Inbound Telephone Coaching means a member enrolled in a Disease Management has the ability to call and speak with a health coach at any time and support is on-going as long as the member remains in the DM program. Nurse line support is offered as a benefit to the general membership and is often a one-time interaction with a member seeking advice.

	Cost of program offering	**Minimum number of health plan members required at employer site to offer this service at no additional charge if this is not a standard benefit**
Template newsletter articles/printed materials for employer use	*Multi, Checkboxes.* 1: Standard benefit for all fully insured lives (included in fully insured premium),, 2: Standard benefit for all self insured ASO lives (no additional fee), 3: Employer Option to buy for fully insured lives, 4: Employer Option to buy for self insured lives, 5: Service/program not available	*Decimal.* From 0 to 1000000000000. N/A OK.
Customized printed materials for employer use	AS ABOVE	AS ABOVE
On-site bio-metric screenings (blood pressure, lab tests, bone density, body fat analysis, etc.)	AS ABOVE	AS ABOVE
Nutrition classes/program	AS ABOVE	AS ABOVE
Fitness classes/program	AS ABOVE	AS ABOVE
Weight loss classes/programs	AS ABOVE	AS ABOVE
Weight management program	AS ABOVE	AS ABOVE
Smoking cessation support program	AS ABOVE	AS ABOVE
24/7 telephonic nurse line	AS ABOVE	AS ABOVE
Inbound telephonic health coaching	AS ABOVE	AS ABOVE

Outbound telephone health coaching	AS ABOVE	AS ABOVE
Member care/service reminders (IVR)	AS ABOVE	AS ABOVE
Member care/service reminders (Paper)	AS ABOVE	AS ABOVE
Targeted personal Health Assessment (HA) formerly known as health risk assessment (HRA)	AS ABOVE	AS ABOVE
In-person lectures or classes	AS ABOVE	AS ABOVE
Social Networks for group-based health management activities, defined as online communities of people who voluntarily share health information or exchange commentary based on a common health issue or interests (e.g., managing diabetes, weight loss, or smoking cessation	AS ABOVE	AS ABOVE

5.3 Health Assessments (HA)

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.3.1 Provide the number of currently enrolled members who completed a Health Assessment (HA), (formerly known as Health Risk Assessment -HRA or PHA- Personal Health Assessment) in the past year. Please provide statewide counts if available. If statewide counts are not available, provide national counts.

If the Plan has partnered with employers to import data from an employer-contracted PHA vendor, enter a number in the fifth row. (see also question 5.3.8 and 5.3.9)

HMO Response	Answer
Geography reported below for HA completion Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked nationally & regionally, including this region (and this region/market response provided below), 2: Participation tracked nationally and for some regions but not this region (national data provided below), 3: Participation only tracked nationally (national data provided below), 4: Participation not tracked regionally or nationally,

	5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on response above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for geography (sum of commercial HMO/POS, PPO and Other Commercial)	*For comparison.* TBD
Enrollment (denominator used to calculate percentage of unique users and ideally should be the total commercial state enrollment. If use can only be tracked nationally, enrollment number here should be the total commercial national number. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of members completing Plan-based PHA in 2012 for regional or national geography as checked above.	*Decimal.* From 0 to 10000000000000000000.
Number of members completing an employer-based vendor PHA in 2012, for regional or national geography as checked above.	*Decimal.* N/A OK. From 0 to 100000000000.
Percent PHA completion regionally or nationally as indicated above (Plan PHA completion number + employer PHA completion number divided by total enrollment)	*For comparison.* Unknown

5.3.2 PPO VERSION OF ABOVE

5.3.3 Identify methods for promoting Health Assessment (HA) (formerly known as Health Risk Assessment – HRA, or PHA- Personal Health Assessment) completion to members. If incentives are used, provide a general description of how the program works. Indicate all that apply. "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member about completion of HA.

HMO Response	**Answer**	**Description**
HA promoted	*Single, Radio group.* 1: Yes, using at least one of the following methods, 2: Yes, but not using any of the following methods below (describe), 3: No	*100 words.*
General messaging on Plan website or member newsletter	*Multi, Checkboxes.* 1: 1-2 X per year, 2: 3-6 X per year, 3: > 6 X per year, 4: None of the above	
Targeted messaging (mail or push e-mail) (describe targeting criteria). "Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member regarding identified conditions based on personal Health Assessment (HA) results. This was formerly referred to as Health Risk Assessment (HRA).	*Single, Radio group.* 1: Yes, 2: No	*Unlimited.* N/A OK.
Financial incentives from Plan to members (describe): (FOR	*Single, Radio group.* 1: Yes,	*Unlimited.* N/A OK.

FULLY INSURED PRODUCTS ONLY)	2: No, 3: Not applicable	
Financial incentives from Plan to employers (describe): (FOR FULLY INSURED PRODUCTS ONLY)	AS ABOVE	AS ABOVE
Promoting use of incentives and working with Purchasers to implement financial incentives for employees (describe)	AS ABOVE	AS ABOVE
Multiple links (3 or more access opportunities) to HA within Plan website (indicate the number of unique links to the HA). Documentation needed, provide in 5.3.5	*Decimal.* From 0 to 100000000000000000. N/A OK.	
Promotion through provider (describe)	*Single, Radio group.* 1: Yes, 2: No	*Unlimited.* N/A OK.
Promotion through health coaches or case managers (describe:)	AS ABOVE	AS ABOVE

5.3.4 PPO VERSION OF ABOVE

5.3.5 If Plan indicated above that HAs are promoted through multiple links on their website, provide documentation for three web access points as Prevention 1. Only documentation of links will be considered by the reviewer. The link should be clearly identified and if not evident, the source of the link, e.g. home page, doctor chooser page, etc., may be delineated.

5.3.6 Indicate manner in which Plan does support or can support administration of employer-sponsored incentives. Check all that apply.

HMO Response	Response	Fee Assessment
Communicate employer incentive plan to members on behalf of employer	*Multi, Checkboxes.* 1: Currently in place for at least one employer, 2: Plan can/will undertake when requested, 3: Plan will not perform this function	*Single, Pull-down list.* 1: Fee routinely assessed, 2: No fee applies, 3: Fee may or may not be assessed based on circumstances or contract
Report HA participation to employer	AS ABOVE	AS ABOVE
Report aggregate HA results to employer for purposes of developing wellness programs	AS ABOVE	AS ABOVE
Based on HA results, recommend to member disease management or wellness program participation required for receipt of incentive	AS ABOVE	AS ABOVE
Track and report member participation in recommended DM or wellness programs to employer	AS ABOVE	AS ABOVE
Track and report outcome metrics (BMI, tobacco cessation) to employer	AS ABOVE	AS ABOVE

Fulfill financial incentives based on employer instruction	AS ABOVE	AS ABOVE
Fulfill non-financial incentives based on employer instruction	AS ABOVE	AS ABOVE

5.3.7 PPO VERSION OF ABOVE

5.3.8 Indicate activities and capabilities supporting the plan's HA programming. Check all that apply.

Multi, Checkboxes.

1: HA Accessibility: BOTH online and in print,
2: HA Accessibility: IVR (interactive voice recognition system),
3: HA Accessibility: Telephone interview with live person,
4: HA Accessibility: Multiple language offerings,
5: Addressing At-risk Behaviors: At point of HA response, risk-factor education is provided to member based on member-specific risk, e.g. at point of “smoking-yes” response, tobacco cessation education is provided as pop-up.,
6: Addressing At-risk Behaviors: Personalized HA report is generated after HA completion that provides member-specific risk modification actions based on responses,
7: Addressing At-risk Behaviors: Members are directed to targeted interactive intervention module for behavior change upon HA completion.,
8: Addressing At-risk Behaviors: Ongoing push messaging for self-care based on member's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the member).,
9: Addressing At-risk Behaviors: Member is automatically enrolled into a disease management or at-risk program based on responses,
10: Addressing At-risk Behaviors: Case manager or health coach outreach call triggered based on HA results,
11: Addressing At-risk Behaviors: Member can elect to have HA results sent electronically to personal physician,
12: Addressing At-risk Behaviors: Member can update responses and track against previous responses,
13: Partnering with Employers: Employer receives trending report comparing current aggregate results to previous aggregate results,
14: Partnering with Employers: Employer can import data from employer-contracted HA vendor.,
15: Plan does not offer an HA

5.4 Cancer Screening Programs and Results

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.4.1 Review the two most recently calculated years of HEDIS results for the HMO Plan (QC 2012 and 2011).

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

	QC 2012	QC 2011, or prior year's HMO QC result
Breast Cancer Screening - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Cervical Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Colorectal Cancer Screening	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

5.4.2 PPO VERSION OF ABOVE

5.4.3 Which of the following member interventions applying to at least 75% of your enrolled membership were used by the Plan in calendar year 2012 to improve cancer screening rates? Indicate all that apply.

	Educational messages identifying screening options discussing risks and benefits	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Breast Cancer Screening	*Single, Radio group.* 1: Yes, 2: No	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not Available
Cervical Cancer Screening	AS ABOVE	AS ABOVE	AS ABOVE
Colorectal Cancer Screening	AS ABOVE	AS ABOVE	AS ABOVE

5.4.4 Provide copies of all member-specific interventions described in Question 5.4.3 as Prevention 2. Reviewer will be looking for evidence of member specificity and indication that service is due, if applicable. Note: if the documentation does not specify that a service is needed, then indicate on the attachment how the reminder is based on missed services vs. a general reminder. Do NOT send more examples than is necessary to demonstrate functionality.

5.5 Immunization Programs

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.5.1 Review the two most recently uploaded years of HEDIS/CAHPS (QC 2012 and QC 2011) results for the HMO Plan. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

	QC 2012, or most current year's HMO result	QC 2011, or prior year's HMO QC result
Childhood Immunization Status - Combo 2	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Immunizations for Adolescents - Combination	AS ABOVE	AS ABOVE
CAHPS Flu Shots for Adults (50-64) (report rolling average)	AS ABOVE	AS ABOVE

5.5.2 PPO VERSION OF ABOVE

5.5.3 Identify member interventions used in calendar year 2012 to improve immunization rates. Check all that apply.

	Response	Member-specific reminders (electronic or written, etc.) sent to members for needed care based on general eligibility (age/gender)	Member-specific reminders for gaps in services based on administrative or clinical information (mail, e-mail/text, automated phone or live outbound telephone calls triggered by the ABSENCE of a service)
Childhood Immunizations	*Single, Radio group.* 1: General education (i.e. - member newsletter), 2: Community/employer immunization events, 3: None of the above	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not available	*Single, Radio group.* 1: Available to > 75% of members, 2: Available to < 75% of members, 3: Not available
Immunizations for Adolescents	AS ABOVE	AS ABOVE	AS ABOVE

5.6 Prevention and Treatment of Tobacco Use

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.6.1 Indicate the number and percent of tobacco dependent commercial members identified and participating in cessation activities during 2012. Please provide statewide counts if available. If statewide counts are not available, provide national counts.

	Answer
Indicate ability to track identification. Statewide	*Multi, Checkboxes.*

tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	1: Identification tracked nationally & Statewide, including this region, 2: Identification tracked nationally and for some regions but not this region, 3: Identification only tracked nationally, 4: Identification not tracked Statewide or nationally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Statewide tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked nationally & Statewide, including this region, 2: Participation tracked nationally and for some regions but not this region, 3: Participation only tracked nationally, 4: Participation not tracked Statewide or nationally, 5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on responses above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) Please verify value and, if necessary, make corrections in the Profile module.	*For comparison.* TBD
Enrollment (denominator used to calculate percentage of unique users and ideally should be the total commercial state enrollment. If use can only be tracked nationally, enrollment number here should be the total commercial national number. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of commercial members individually identified as tobacco dependent in 2012 as of December 2012	*Decimal.* From 0 to 1000000000.
% of members identified as tobacco dependent	*For comparison.* 0.00%
Number of members participating in smoking cessation program during 2012 as of December 2012	*Decimal.* From 0 to 1000000000.
% of identified tobacco dependent members participating in smoking cessation program (# program participants divided by # identified smokers)	*For comparison.* 0.00%

5.6.2 Review the HMO QC 2012 CAHPS data regarding the Plan's Statewide percentage of current smokers.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	Answer
HMO QC 2012CAHPS DATA	
Percentage that are current smokers	*Percent.*
Percent of current tobacco users (estimated by CAHPS) that are identified by the plan as tobacco dependent	*For comparison.* N/A%

5.6.3 PPO VERSION OF ABOVE

5.6.4 The CDC recommends that tobacco use be screened at every medical encounter. How does the plan monitor that clinicians screen adults for tobacco use at every provider visit?

	Type of Monitoring	Detail
Screening adults for tobacco use at every medical encounter	*Multi, Checkboxes.* 1: Chart audit, 2. Electronic Medical Records, 3: Survey/Self report, 4: Other monitoring method (Describe in detail box), 4: This screening is recommended, but not monitored, 6: This screening is not recommended	*200 words.*

5.6.5 If Plan supports a Smoking Cessation Support Program, identify how pharmaceutical coverage was covered within the program in calendar year 2012. Refer to response in 5.2.1.

HMO Response	Coverage Options	Copay, deductible, or incentive plan options
Over-the-counter aids (NRT patch, gum, etc.) discounted, free, or available at copay	*Multi, Checkboxes.* 1: Included as part of tobacco cessation program with no additional fee, 2: Available in tobacco cessation program with an additional fee, 3: Available in tobacco cessation program but may require an additional fee, depending on contract, 4: No tobacco cessation program, but tobacco cessation pharmaceuticals covered under pharmacy benefit for fully insured lives, 5. No tobacco cessation program, but tobacco cessation pharmaceuticals covered under pharmacy benefit for self-insured lives 6: Not included	*Multi, Checkboxes.* 1: Standard copay/discount only, 2: Copay/discount or deductible incentive is variable based on program participation, 3: Medication is available on lowest cost (or no cost) tier, 4: Limitation on number of fills per year, 5: Prior authorization or step therapy required, 6: Available as rider only
Bupropion (generic Zyban)	AS ABOVE	AS ABOVE
Zyban	AS ABOVE	AS ABOVE
Chantix	AS ABOVE	AS ABOVE

5.6.6 PPO VERSION OF ABOVE

5.6.7 Please refer to plan response in 5.2.1 and 5.6.1 as response should be consistent with plan response in those questions. Identify behavioral change interventions in the tobacco cessation program in calendar year 2012. These questions are referencing stand-alone tobacco cessation programs. Enter “Zero” if the intervention is not provided to members in the tobacco cessation program. Check all that apply.

If "Percent receiving intervention" is shown as greater than 100%, please review the response to 5.6.1.

	Availability of intervention	**Cost of intervention**	**Number of participants in 2012 (Statewide preferred - refer back to 5.6.1)**	**Is Number of participants provided Statewide or national number?**	**Percent receiving intervention (denominator is from 5.6.1 second to last row)**
Quit kit or tool kit mailed to member’s home	*Single, Pull-down list.* 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in tobacco cessation program	*Multi, Checkboxes.* 1: Included as part of tobacco cessation program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No tobacco cessation program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No tobacco cessation program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee) 6: No tobacco cessation program but intervention available outside of a specific program as a buy-up option for fully insured lives 7: No tobacco cessation program but intervention available outside of a specific program as buy-up option for self-insured lives 8: Not available	*Decimal.* From 0 to 10000000000000.	*Single, Radio group.* 1: Statewide, 2: National	Unknown
Interactive electronic support	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online professionally facilitated group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online chat sessions non-facilitated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

Telephonic counseling program	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In person classes or group sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Individual in-person counseling (this does NOT include standard behavioral health therapy where addictions may be addressed)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

5.6.8 If the plan provides in-person or telephonic counseling, please indicate all of the following that describe the most intensive program below.

Multi, Checkboxes.
1: Each course of treatment (member's term of participation in a smoking cessation program) routinely includes up to 300 minutes of counseling,
2: At least two courses of treatment (original + 1 extra) are routinely available per year for members who don't succeed at the first attempt,
3: There are at least 12 sessions available per year to smokers,
4: Counseling not included

5.6.9 Identify Plan activities in calendar year 2012 for practitioner education and support related to tobacco cessation. Check all that apply. If any of the following four (4) activities are selected, documentation to support must be attached in the following question as Prevention 3. The following selections need documentation:

1: General communication to providers announcing resources/programs available for tobacco cessation
2: Comparative reporting
3: Member specific reminders to screen
4: Member specific reminders to treat

	Activities
Education/ Information	*Multi, Checkboxes.* 1: General education of guidelines and health plan program offerings, 2: Notification of member identification, 3: CME credit for smoking cessation education, 4: Comparative performance reports (identification, referral, quit rates, etc.), 5: Promotion of the appropriate smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 9402, and HCPCS G0375, G0376) (describe), 6: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of member materials for provider use and dissemination, 2: Member-specific reports or reminders to screen, 3: Member-specific reports or reminders to treat (smoking status already known), 4: Routine progress updates on members in outbound telephone management program, 5: None of the above

Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Plan reimburses for appropriate use of smoking-related CPT or diagnosis coding (e.g. ICD 305.1, CPT 99401, 99402, and HCPCS G0375, G0376), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice support	*Multi, Checkboxes.* 1: The plan provides care managers that can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports, 5: Care plan approval, 6: None of the above
Description	*200 words.*

5.6.10 If plan selected response options 1 and 4 in education/information and options 2 and 3 in patient support in question above, provide evidence of practitioner support as Prevention 3. Only include the minimum documentation necessary to demonstrate the activity. A maximum of one page per activity will be allowed.

Multi, Checkboxes.

1: General communication to providers announcing resources/programs available for tobacco cessation,

2: Comparative reporting,

3: Member specific reminders to screen,

4: Member specific reminders to treat,

5: Prevention 3 not provided

5.6.11 Review the most recent HMO uploaded program results for the tobacco cessation program from QC 2012 and QC 2011.

For the non-NCQA/QC measures "Program defined 6-month quit rate and 12 month quit rate" - please provide the most recent 2 years of information. Indicate all that apply.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

	2012 HMO and QC 2012 results	2011 HMO and QC 2011 results	Describe measure methodology/definition (non HEDIS measures)	Not tracked
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers To Quit (report rolling average)	National Business Coalition on Health (individually). *Percent.* From -10 to 100.	National Business Coalition on Health (individually). *Percent.* From -10 to 100.		
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications (report rolling average)	National Business Coalition on Health (individually). *Percent.* From -10 to 100.	National Business Coalition on Health (individually). *Percent.* From -10 to 100.		
HEDIS Medical Assistance with Smoking Cessation - Discussing Strategies (report rolling average)	National Business Coalition on Health (individually). *Percent.* From -10 to 100.	National Business Coalition on Health (individually). *Percent.* From -10 to 100.		
Program defined 6-month quit rate	*Percent.* From 0 to 100.	*Percent.*	*Unlimited.*	*Multi, Checkboxes - optional.* 1: Not tracked
Program defined 12-month quit rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other (describe in "describe measure...")	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

5.6.12 PPO VERSION OF ABOVE

5.7 Obesity

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.7.1 Review the 2012 and 2011 QC HEDIS uploaded results for the HMO Plan.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is may be auto-populated.

	2012 HMO QC results	2011 HMO QC results
Weight assessment and counseling for nutrition and physical activity for children and adolescents- BMI percentile. (Total)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for nutrition (Total)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Weight assessment and counseling for nutrition and physical activity for children and adolescents- counseling for physical activity (Total)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Adult BMI assessment (Total)	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

5.7.2 PPO VERSION OF ABOVE

5.7.3 Indicate the number of obese members identified and participating in weight management activities during 2012. Do not report general prevalence.

Please provide statewide counts if available. If statewide counts are not available, provide national counts.

	Answer
Indicate ability to track identification. Statewide tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Identification tracked nationally & Statewide, including this state 2: Identification tracked nationally and for some states but not this state, 3: Identification only tracked nationally, 4: Identification not tracked Statewide or nationally, 5: Identification can be tracked at individual employer level
Indicate ability to track participation. Statewide tracking is preferred. Please select only ONE of response options 1-4 and include response option 5 if applicable	*Multi, Checkboxes.* 1: Participation tracked nationally & Statewide, including this state, 2: Participation tracked nationally and for some states but not this state, 3: Participation only tracked nationally, 4: Participation not tracked Statewide or nationally, 5: Participation can be tracked at individual employer level
Geography for data below (automatically determined based on responses above)	*For comparison.* 4: Awaiting response to rows above
Total commercial enrollment for TBD geography (sum of commercial HMO/POS, PPO and Other Commercial) Please verify value and, if necessary, make corrections in the Profile module.	*For comparison.* TBD
Enrollment (denominator used to calculate percentage of unique users and ideally should be the total commercial state enrollment. If use can only be tracked nationally, enrollment number here should be the total commercial national number. If Plan has and tracks use by Medi-Cal members as well, enrollment number here should include Medi-Cal numbers.)	*Decimal.* From 0 to 10000000000000000000.
Number of commercial plan members identified as obese in 2012 as of December 2012	*Decimal.* From 0 to 1000000000.

% of members identified as obese	*For comparison.* 0.00%
Number of commercial plan members participating in weight management program during 2012 as of December 2012	*Decimal.* From 0 to 1000000000.
% of members identified as obese who are participating in weight management program (# program participants divided by # of identified obese)	*For comparison.* 0.00%

5.7.4 Please refer to plan response in question above as response should be consistent with plan response in 5.7.3. Please also refer to response in 5.2.1. For plan's total commercial book of business, identify the interventions offered in calendar year 2012 as part of your weight management program (and are not limited to members seeking bariatric surgery). Do not consider obesity-centric counseling/behavior change interventions that are associated with other disease management programming. These questions are referencing stand-alone weight management services.
Enter "Zero" if the intervention is not provided to members in the weight management program. Check all that apply. Note that selection of the following four (4) response options requires documentation as Prevention 4:

1: Online interactive support, 2: Self-management tools (not online), 3: Family counseling, 4: Biometric devices

If "Percent receiving intervention" is shown as greater than 100%, please review the response to 5.7.3.

	Availability of intervention	**Cost of intervention**	**Number of participants in 2012-Statewide preferred - refer to question above**	**Is Number of participants provided Statewide or national?**	**Percent receiving intervention (denominator is from 5.7.3 second to last row)**
Printed (not online) self-management support tools such as BMI wheels, pedometer, or daily food and activity logs	*Single, Pull-down list.* 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one, 4: Available through some medical groups or practitioners, but not plan-monitored or tracked, 5: Not included in weight management program	*Multi, Checkboxes.* 1: Included as part of weight management program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No weight management program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No weight management program but intervention available outside of a specific program as standard benefit for self-insured lives (part of the ASO fee) 6: No weight management program but intervention available outside of a specific program as a buy-up option for fully insured lives 7: No weight management program but intervention available outside of a specific program as buy-up option for self-insured lives 8: Not available	*Decimal.* From 0 to 10000000000000.	*Single, Radio group.* 1: Statewide, 2: National	Unknown
Web and printed	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

educational materials about BMI and importance of maintaining a healthy weight					
Online interactive support that might include tools and/or chat sessions	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Telephonic coaching that is obesity-centric. (Obesity is key driver of contact as opposed to discussion in context of some other condition)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
In-person group sessions or classes that are obesity centric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Obesity-centric Telephonic or in-person family counseling to support behavior modification	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pedometer and/or biometric scale or other device for home monitoring and that electronically feeds a PHR or EMR	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pharmacological Therapies	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Benefit coverage of FDA approved weight loss drugs	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Other					
Affinity programs (e.g. - discounts for Weight Watchers, fitness center discounts)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

5.7.5 If the Plan selected any of the following weight management activities in the question above, please provide evidence as Prevention 4. Only provide the minimum number of pages as indicated at question above to demonstrate activity. The following evidence is provided:

Multi, Checkboxes.

1: Online interactive support,
2: Self-management tools (not online),
3: Family counseling,
4: Biometric devices,
5: Prevention 4 is not provided

5.7.6 If the Plan indicated telephonic (obesity centric), in-person individual or group counseling in question 5.7.4 above, please check all that apply about the program

Multi, Checkboxes.

1: Program includes at least 2 sessions per month,
2: There is coverage for at least six sessions per year,
3: Additional sessions are covered if medically necessary,
4: Counseling sessions do not require a copay,
5: Counseling is not offered

5.7.7 If the Plan indicated coverage for FDA approved weight loss drugs in question 5.7.4 above, check all that apply.

HMO Response	Coverage options	Copay, deductible, or incentive plan options
Over-the-counter aids (e.g. Alli) discounted, free, or available at copay	*Multi, Checkboxes.* 1: Included as part of weight management program with no additional fee, 2: Available in weight management program with an additional fee, 3: Available in weight management program, but may require an additional fee, depending on contract, 4: No weight management program, but weight loss drugs covered under pharmacy benefit for fully insured lives, 5: No weight management program, but weight loss drugs covered under pharmacy benefit for self-insured lives, 6: Not covered	*Multi, Checkboxes.* 1: Standard copay/discount only, 2: Copay/discount or deductible incentive is variable based on program participation, 3: Medication is available on lowest cost tier, 4: Limitation on number of fills per year, 5: Prior authorization or step therapy required, 6: Available as rider only
Xenical (Orlistat)	AS ABOVE	AS ABOVE
Phentermine or branded equivalents	AS ABOVE	AS ABOVE

5.7.8 PPO VERSION OF ABOVE

5.7.9 For the HMO product, if the plan provides coverage for FDA approved weight loss drugs, describe the eligibility criteria for coverage. For more information on these standards, please see the Purchaser's Guide to Clinical Preventive Services. http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf (Check all that apply)

Multi, Checkboxes.

1: Eligibility criteria indicates coverage for members > 18 years,
2: Eligibility criteria indicates BMI > 30 if no other co-morbidities exist,
3: Eligibility criteria indicates BMI > 27 with at least one other major risk factor for cardiovascular disease,
4: Plan provides coverage, but uses other criteria for coverage (Describe),
5: Plan provides coverage, but no criteria for coverage,
6: No coverage for FDA approved weight loss drugs

5.7.10 PPO VERSION OF ABOVE

5.7.11 Identify Plan activities in calendar year 2012 for practitioner education and support related to obesity management. Check all that apply. If any of the following four (4) activities are selected, documentation must be provided as Prevention 5 in the following question:

1:Member-specific reports or reminders to treat 2: Periodic member program reports, 3: Comparative performance reports, and 4: General communication to providers announcing resources/programs available for weight management services

	Activities
Education/Information	*Multi, Checkboxes.* 1: General education of guidelines and health plan program offerings, 2: Educate providers about screening for obesity in children, 3: Notification of member identification, 4: CME credit for obesity management education, 5: Comparative performance reports (identification, referral, quit rates, etc.), 6: Promotes use of Obesity ICD-9 coding (e.g. 278.0) (describe), 7: Distribution of BMI calculator to physicians, 8: None of the above
Patient Support	*Multi, Checkboxes.* 1: Supply of materials/education/information therapy for provision to members, 2: Member-specific reports or reminders to screen, 3: Member-specific reports or reminders to treat (obesity status already known), 4: Periodic reports on members enrolled in support programs, 5: None of the above
Incentives	*Multi, Checkboxes.* 1: Incentives to conduct screening (describe), 2: Incentive to refer to program or treat (describe), 3: Plan reimburses for appropriate use of Obesity ICD-9 coding (e.g. 278.0), 4: Incentives to obtain NCQA Physician Recognition – (e.g. Physician Practice Connections or Patient Centered Medical Home), 5: None of the above
Practice Support	*Multi, Checkboxes.* 1: The plan provides care managers that can interact with members on behalf of practice (e.g. call members on behalf of practice), 2: Practice support for work flow change to support screening or treatment (describe), 3: Support for office practice redesign (i.e. ability to track patients) (describe), 4: Opportunity to correct information on member-specific reports (information must be used by the Plan in generating future reports, 5: Care plan approval, 6: None of the above
Description	*200 words.*

5.7.12 Provide evidence of practitioner support that is member or performance specific as Prevention 5. Prevention 5 is provided

Multi, Checkboxes.

1: Member-specific reports or reminders to treat,

2: Periodic member program reports,

3: Comparative performance reports,

4: General communication to providers announcing resources/programs available for weight management services,

5: Prevention 5 is not provided

5.7.13 Does the Plan track any of the following outcomes measures related to obesity? Check all that apply.

Multi, Checkboxes.
1: Percent change in member BMI,
2: Percent of members losing some % of body weight,
3: Percent of obese members enrolled in weight management counseling program (program participation rates),
4: Percent of members maintaining weight loss over one year interval,
5: Reduction in comorbidities in overweight population,
6: Other (describe in detail box below):,
7: No outcomes tracked

5.8 Obstetrics and Maternity and Child

Additional information not addressed elsewhere within this section can be provided in Section 5.9.

5.8.1 Which of the following activities does the plan undertake to promote pre-conception counseling? Pre-conception counseling is defined as counseling or a consult with women of child-bearing age regardless of whether the women are actively attempting or planning a pregnancy. For more information about preconception counseling, see http://www.cdc.gov/ncbddd/preconception/ A "Reproductive Life Plan" is a written account of a woman's general plan for pregnancy and childbirth and may include elements of timing, budgeting, birth control, delivery preferences, principles of child-rearing, etc. Check all that apply.

	Answer
Plan promotes preconception counseling	*Single, Radio group.* 1: Yes, 2: No
General education to practitioners about importance of preconception counseling for all women of child-bearing age	AS ABOVE
Targeted education to practitioners treating women with pre-existing health conditions, (e.g. diabetes, HIV, high blood pressure, etc.) about the importance of pre-conception counseling	AS ABOVE
General education to women of child bearing age about the importance of pre-conception counseling in newsletters, etc.	AS ABOVE
Targeted education to women with pre-existing health conditions, (e.g. diabetes, HIV, high blood pressure, etc.) about the importance of preconception counseling	AS ABOVE
Templates or other tools to assist practitioners with the development of a Reproductive Life Plan (describe):	*200 words.*
Interactive web tool for self-development of Reproductive Life Plan	*Single, Radio group.* 1: Yes, 2: No
Endorses or promotes screening for known risk factors according to guidelines set forth by the American College of Obstetrics and Gynecology for all women who are planning a pregnancy (describe):	*200 words.*
Other (describe):	*Unlimited.* N/A OK.

5.8.2 How does the plan monitor that practitioners are screening pregnant women for tobacco and alcohol use?

	Type of Monitoring	Detail
Screening pregnant women for alcohol use at the beginning of each pregnancy	*Multi, Checkboxes.* 1: Screening is not monitored, 2: Chart audit, 3: Survey/Self report, 4: Other monitoring method (Describe in detail box), 5: This screening is recommended, but not monitored, 6: This screening is not recommended	*200 words.*
Screening pregnant women for tobacco use and counseling to quit at every provider visit	AS ABOVE	AS ABOVE

5.8.3 Indicate all of the following that describe the Plan's policies regarding normal (not high risk) labor and delivery. Check all that apply.

Multi, Checkboxes.
1: Includes one pre-conception pregnancy planning session as part of the prenatal set of services,
2: Mid-wives credentialed and available for use as primary provider,
3: Coverage for Doula involvement in the delivery,
4: Coverage for home health nurse visit post-discharge,
5: Systematic screening for post partum depression (describe in detail box below),
6: None of the above

5.8.4 Please report the 2012 and 2011 Cesarean delivery rates and VBAC rates using the AHRQ, NQF and Joint Commission specifications.

Detailed specifications can be accessed here:

AHRQ: Cesarean Delivery Rate: http://www.qualityindicators.ahrq.gov/downloads/Modules/IQI/V44/TechSpecs/IQI%2021%20Cesarean%20Delivery%20Rate.pdf.

NQF: NTSV Cesarean Rate: http://manual.jointcommission.org/releases/TJC2010A/MIF0166.html

Joint Commission: Rate of Elective Deliveries: http://manual.jointcommission.org/releases/TJC2012A/MIF0167.html

AHRQ: VBAC Rate Uncomplicated: http://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V43a/TechSpecs/IQI%2022%20Vaginal%20Birth%20After%20Cesarean%20(VBAC)%20Rate%20Uncomplicated.pdf

	Calculated	2012 national Rate	2011 national Rate	2012 rate in market	2011 Rate in market
AHRQ Cesarean Delivery Rate	*Single, Radio group.* 1: Calculated, 2: Not calculated	*Percent.* N/A OK.	*Percent.* N/A OK.	*Percent.*	*Percent.*
NQF NTSV Cesarean Delivery Rate	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Joint Commission Rate of Elective Deliveries	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
AHRQ VBAC Rate Uncomplicated	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
NQF NICU Admission Rates	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

5.8.5 Review the two most recently uploaded QC 2012 and QC 2011 HMO results for the Plan for each measure listed. The HEDIS measure eligible for rotation for QC 2012 is Prenatal and Postpartum Care. If plan rotated Prenatal and Postpartum Care for QC 2012, QC 2012 would be based on QC 2011, so the prior year data that would be uploaded would be QC 2010.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

	QC 2012, or most current year's HMO result	QC 2011, or prior year's HMO QC result
Chlamydia Screening in Women - Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Prenatal and Postpartum Care - Timeliness of Prenatal Care	AS ABOVE	AS ABOVE
Prenatal and Postpartum Care - Postpartum Care	AS ABOVE	AS ABOVE
Well-Child Visits in the first 15 months of life (6 or more visits)	AS ABOVE	AS ABOVE
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	AS ABOVE	AS ABOVE
Adolescent Well-Care Visits	AS ABOVE	AS ABOVE

5.8.6 PPO VERSION OF ABOVE

5.8.7 Identify Plan activities in calendar year 2012 for payment, education and policy initiatives designed to address the rising rates of cesarean deliveries and elective inductions. Check all that apply. **Briefly describe activities and indicate whether related to cesarean delivery and/or inductions, and *include relevant results of***

***efforts*.** Include in the description any educational offerings including which condition (Inductions or C-Delivery) is targeted.

Please ensure your response in 3.7.6 is consistent with your response to this question.

	Activities	Description (are responses related to cesarean delivery or inductions, other payment model, results
Payment	*Multi, Checkboxes.* 1: Bundled payment for professional fee for labor and delivery (or other scope of maternity care), 2: Bundled payment for facility fee for labor and delivery (or other scope of maternity care), 3: Bundled payment for professional and facility fee for labor and delivery (or other scope of maternity care), 4: Blended single payment for cesarean delivery and vaginal births for professionals, 5: Blended single payment for cesarean delivery and vaginal births for facilities, 6: Financial incentives or penalties for professionals to reduce elective cesarean deliveries and/or inductions, 7: Financial incentives or penalties for facilities to reduce elective cesarean deliveries and/or inductions, 8. Other (describe) 9: None of the above	
Education	*Multi, Checkboxes.* 1: Supply of member education materials for provider use and dissemination, 2: Direct member education (describe), 3: Practitioner education (describe), 4: Facility education (describe), 5: None of the above	
Policy	*Multi, Checkboxes.* 1: Contracts establishing required changes in facility policy regarding elective births prior to 39 weeks, 2: Contracts establishing required changes in professional policy regarding elective births prior to 39 weeks, 3. Credential certified nurse midwives and certified midwives, 4. None of the above	

5.9 Other Information

5.9.1 If the Plan would like to provide additional information about the Prevention and Health Promotion activities that was not reflected in this section, provide as Prevention 6.

6 Chronic Disease Management

6.1 Instructions

6.1.1 You may rely on the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

6.1.2 All attachments to this module must be labeled as "DM #" and submitted electronically. If more than one attachment is needed for a particular response, they should be labeled DM 1a, DM 1b, DM 1c, etc. Please keep the number of attachments to the minimum needed to demonstrate your related RFI responses.

6.1.3 The Plan is asked to describe its disease management program organization, including the use of outside vendors. Disease management programs consist of formal programs that (1) identify members with chronic disease, (2) conduct member and practitioner outreach for compliance and health improvement, and (3) address care coordination. Educational messages only are insufficient for consideration of a formal program. Plans that use vendors for disease management should coordinate their answers with their vendor.

6.1.4 The chronic disease management module focuses on Coronary Artery Disease, and Diabetes. Asthma was eliminated as an area of focus for 2009 due to the limited value of the HEDIS indicator and relatively high process scores. Back pain was eliminated in 2010 because the condition did not coordinate well with diabetes and CAD. Questions are asked in "Program Scope" about other clinical programs to understand breadth of the Plan's disease management efforts. Employers may request information on these programs outside of the eValue8 initiative.

6.1.5 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been auto populated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

6.1.6 Plan activities must be in place by the date of this RFI submission for credit to be awarded.

6.2 Program Scope & Coordination

Additional information not addressed elsewhere within this section can be provided in Section 6.7.

6.2.1 For the commercial book of business, indicate the reach of disease management programs offered. If a condition is only managed as a comorbidity within another program, the Plan should indicate the condition is managed only as a comorbidity and identify (as text in the last column) the primary condition(s) linked to the comorbidity. The distinction "available to all" versus "an option to purchase" should be provided only for these primary managed conditions where the Plan proactively identifies all members with the condition for program interventions - not just among these who have been identified with another condition (not comorbidity managed conditions). If the program is administered fully or jointly indicate the vendor name.

If response for column "Reach of disease management programs offered" differs based on product offered (HMO versus PPO) and plan is responding for BOTH products - please select the option that covers most of the membership (most common) and note the other in the additional information section.

	Reach of disease management programs offered	Cost of Program Availability	Vendor Name if plan outsources or jointly administers	*Specify primary condition(s) (If applicable)
Alzheimer's disease	*Multi, Checkboxes.* 1: Plan-wide and available to all commercial members identified with condition,, 2: Managed only as a comorbidity (*specify primary condition(s)),, 3: Available in all markets including this one, 4: Available only in specific markets including this one, 5: Available only in specific markets BUT NOT this one, 6: No disease management program	*Multi, Checkboxes.* 1: Available to fully insured members as part of standard premium, 2: Available as part of standard ASO fee for self-insured members (no additional fee assessed), 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members	*50 words.* N/A OK.	*65 words.*
Arthritis (osteo and/or rheumatoid)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma – Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Asthma - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Back pain	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
CAD (CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis.)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Cancer	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Chronic obstructive pulmonary disease (COPD)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Congestive heart failure (CHF)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Adult	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Diabetes - Pediatric	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

High risk pregnancy	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hyperlipidemia	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Hypertension	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Migraine management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Pain management	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Stroke	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Risk factor based total population management (Not disease specific)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

6.2.2 For patient-centered care, it is important that outreach to patients is seamless and coordinated. Select the one response that best describes the Plan's Disease Management (DM) system administration arrangement.

Select the first response choice in each row “Data is electronically populated in a unified record for DM care management” ONLY IF 1) the information is electronically entered into the record from another electronic source like claims or a web-based electronic personal health assessment tool without manual re-entry or entry resulting from contact with the plan member AND 2) there is a single case record per member that unifies all care management functions conducted by the plan, including large case management, disease management, health and wellness coaching, etc.

Response option 1 can also be selected IF the nurse/case manager enters their notes directly into an electronic DM case record.

	System administration arrangement for disease management
Inpatient medical claims/encounter data	*Single, Radio group.* 1: Data is electronically populated in a unified record for DM care management for all members, 2: Data is manually entered into a unified record for all members, 3: Data is electronically populated in a unified record for DM care management for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH),, 4: Data is manually entered into a unified record for SOME (NOT ALL) members e.g. in pilot program (e.g., PCMH),, 5: This functionality / element is not available or is manually entered by care management staff
Medical claims/encounter data	AS ABOVE
Pharmacy claims data	AS ABOVE
Lab test claims data	AS ABOVE
Lab values	AS ABOVE
Behavioral health claims/encounter data	AS ABOVE

Member response to a Health Assessment (HA), formerly known as PHA or HRA) if available	AS ABOVE
Results from home monitoring devices (electronic scales, Health Buddy, heart failure monitoring devices, etc.)	AS ABOVE
Results from worksite biometric or worksite clinic sources	AS ABOVE
Information from case manager or nurses notes	AS ABOVE

6.2.3 How does the Plan determine and ensure that members with chronic diseases are screened for depression based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis. Availability of the general Plan Health Assessment does not qualify unless it is specifically promoted to members in the DM program (not just through general messages to all health plan members) and used by the DM program staff.

	Response	**Means of Determination**	**If "Other Means of Determination" selected as response - describe**
Coronary Artery Disease	*Single, Radio group.* 1: Depression is not assessed, 2: Survey/nurse assessment of select DM program members (only high risk individuals receive screening), 3: Survey/nurse assessment of select DM program members (medium and high risk individuals receive screening), 4: Survey/nurse assessment of all DM program members (all risk levels receive screening)	*Multi, Checkboxes.* 1: Survey, 2: Nurse, 3: IVR, 4: Other (Specify)	*100 words.*
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE

6.2.4 How does the Plan determine and ensure members are screened and, if appropriate, treated for overweight/obesity (BMI) based on the level of risk segmentation? Availability of the general Plan Health Assessment does not qualify unless it is specifically promoted to members in the DM program (not just through general messages to all health plan members) and used by the DM program staff. Check all that apply.

	Response	**Means of Determination**	**If "Other Means of Determination" selected as response - describe**
Coronary Artery Disease	*Single, Radio group.* 1: BMI is not assessed, 2: Survey/nurse assessment of select DM program members (only high risk individuals receive screening), 3: Survey/nurse assessment of select DM program members (medium and high risk individuals receive screening), 4: Survey/nurse assessment of all DM program members (all risk levels	*Multi, Checkboxes.* 1: Survey, 2: Nurse, 3: IVR, 4: Other (specify)	*100 words.*

	receive screening)		
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE

6.2.5 Describe how (1) care coordination is handled for an individual member across comorbid conditions (e.g. a member diagnosed with coronary artery disease and diabetes or depression). If one or more disease management programs are outsourced to a vendor, identify how the vendor manages care coordination for an individual member across comorbid conditions; and (2) how pharmacy management is integrated in chronic disease management programs Disease management programs consist of formal programs that (1) identify members with chronic disease, (2) conduct member and practitioner outreach for compliance and health improvement, and (3) address care coordination. Educational messages only are insufficient for consideration of a formal program.

	Response
Describe how care is coordinated for member with co-morbid conditions including depression	*200 words.*
Describe how pharmacy management is integrated in CDM (chronic disease management) programs	*200 words.*

6.2.6 For patient-centered care, it is important that outreach to patients is seamless and coordinated. Select the one response that best describes the Plan's Medical Management Services. Check all that apply.

	Medical Management Services	**Describe**
When do you initiate outreach for case management referrals?	*Single, Radio group.* 1: Within 24-48 hours 2: Within 3-5 business days 3: Within 6-10 business days 4: Other (describe)	*50 words*
Do you have a program that provides help to an individual transitioning between care settings?	*Multi, checkboxes* 1: Home to and from Hospital 2: Skilled Nursing Care to and from Hospital 3: Rehabilitation Care to and from Hospital 4: Other (describe)	*500 Words*
Describe how you develop and administer a high-intensity case management program for the most medically complex patients.	*Single, Radio group.* 1: Measurement strategy in place (describe) 2: No Measurement strategy in place	*Describe* *200 Words*
Describe the measurement strategy in your high-intensity case management programs.	*Multi, checkboxes* 1: Member Satisfaction 2: Admission Rates 3: Complication Rates 4: Readmission Rates 5: Clinical Outcome Quality 6: Other (describe)	*Describe* *500 Words*

6.3 Member Identification and Support

Additional information not addressed elsewhere within this section can be provided in Section 6.7.

6.3.1 For the total commercial book of business in this market, please provide (1) the number of members aged 18 and above in first row, (2) the number of members aged 18 and above with CAD using the NCQA “Eligible Population” definition for Cardiovascular Disease in the second row, and (3) the number of members eligible for participation in the DM program based on Plan’s criteria (NOT Prevalence). Refer back to Plan response in 6.2.1.

Starting at row 4, based on the Plan’s stratification of members with CAD, indicate the types of interventions that are received by the population based on the level of risk segmentation. CAD refers to members with a diagnosis of coronary artery disease or those who have had an acute cardiac event. Hypertension and hypercholesterolemia are considered risk factors for CAD and may be managed as comorbidities but should not be counted as part of the CAD population in the absence of an actual diagnosis. Enter “Zero” if the intervention is not provided to members with CAD. Select “Interactive IVR with information capture” only if it involves record updates and/or triggering additional intervention. Select “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program. Select online interactive self management only if the application involves customized information based on branch logic. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include static web information. A member is “actively engaged” in the outbound telephonic program if they participate beyond the initial coaching call.

	Number of members as specified in rows 1, 2 and 3	**Indicate if intervention Offered to CAD Patients in this state/market**	**Number of members in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)**	**Is Intervention standard or buy-up option(cost of intervention)**	**Risk strata that receives this intervention**	**Autocalcalculated % of HEDIS CAD eligibles who received intervention**	**Autocalcalculated % of Plan CAD eligibles who received intervention**
Number of members aged 18 and above in this market	*Decimal.*						
Using the NCQA “Eligible Population” definition for Cardiovascular Disease on pages 132-133 of the 2012 HEDIS Technical Specifications Vol 2., provide	*Decimal.*						

number of members 18 and above with CAD							
Using the plan's own criteria, provide number of members eligible to participate in CAD DM program	*Decimal.*						
General member education (e.g., newsletters)		*Multi, Checkboxes.* 1: HMO, 2: PPO, 3: Neither	*Decimal.* From 0 to 1000000000000000.	*Multi, Checkboxes.* 1: Included as part of CAD program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No CAD program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No CAD program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No CAD program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No CAD program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	*Multi, Checkboxes.* 1: Low, 2: Medium, 3: High risk, 4: No stratification	Unknown	Unknown

General care education/reminders based on condition alone (e.g., personalized letter)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Member-specific reminders for a known gap in clinical/diagnostic maintenance services Answer "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Member-specific reminders for medication events (e.g., level of use, failure to refill) Answer "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program. (Documentation needed)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)							
Self-initiated text/email messaging	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Interactive IVR with information capture Answer "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention.	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
IVR with outbound messaging only	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Live outbound telephonic coaching program (count only members that are successfully engaged)	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

6.3.2 For the total commercial book of business in this market, please provide (1) the number of members aged 18 and above in the first row, (2) the number of members aged 18 and above with Diabetes using the NCQA "Eligible Population" definition for Diabetes in

the second row, and (3) the Members eligible for participation in the DM program based on Plan's criteria (NOT Prevalence). Refer back to Plan response in 6.2.1.

Starting at Row 4, based on the Plan's stratification of members with Diabetes, indicate the types of interventions that are received by the population based on the level of risk segmentation. Enter "Zero" if the intervention is not provided to members with Diabetes. Select "Interactive IVR with information capture" only if it involves record updates and/or triggering additional intervention. Select "member-specific reminders" only if it involves reminders that are independent of the live outbound telephonic program. Select online interactive self-management only if the application involves customized information based on branch logic. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include static web information. A member is "actively engaged" in the outbound telephonic program if they participate beyond the initial coaching call.

	Number of members as specified in rows 1, 2 and 3	**Indicate if intervention Offered to PPO Diabetes Patients in this state/market**	**Number of members 18 years and above in this state/market receiving intervention (if plan offers intervention but does not track participation, enter zero)**	**Is intervention a standard or buy-up option (cost of intervention)**	**Risk strata that receives this intervention**	**Auto calculated % of HEDIS Diabetes eligibles who received intervention**	**Auto calculated % of HEDIS Diabetes eligibles who received intervention**
Number of members aged 18 and above in this market	*Decimal.*						
Using the NCQA "Eligible Population" definition for Diabetes on pages 146-146 of the 2012 HEDIS Technical Specifications Vol 2., provide number of members 18 and above with Diabetes	*Decimal.*						
Using the plan's own criteria, provide number of members eligible to participate in diabetes DM program	*Decimal.*						
General member education (e.g.,		*Multi, Checkboxes.*	*Decimal.* From 0 to 10000000000	*Multi, Checkboxes.* 1: Included as part	*Multi, Checkboxes.*	Unknown	Unknown

newsletters)		1: HMO, 2: PPO, 3: Neither	0.	of Diabetes program with no additional fee, 2: Inclusion of this intervention requires an additional fee, 3: Inclusion of this intervention sometimes requires additional fee, depending on contract, 4: No Diabetes program but intervention available outside of a specific program as a standard benefit for fully insured lives, 5: No Diabetes program but intervention available outside of a specific program as a standard benefit for self-insured lives (part of the ASO fee), 6: No Diabetes program but intervention available outside of a specific program as a buy-up option for fully insured lives, 7: No Diabetes program but intervention available outside of a specific program as buy-up option for self-insured lives, 8: Not available	1: Low, 2: Medium, 3: High risk, 4: No stratificatio n		
General care education/reminders based on condition alone (e.g., personalized letter)		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Member-specific reminders for due or overdue clinical/diagnostic maintenance services Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program (Documentation needed)		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

Member-specific reminders for medication events (e.g., level of use, failure to refill) Answer “member-specific reminders” only if it involves reminders that are independent of the live outbound telephonic program (Documentation needed)		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Online interactive self-management support. "Online self-management support" is an intervention that includes two-way electronic communication between the Plan and the member. Examples include devices that monitor weight, lab levels, etc. as well as web-support activities that are customized and tailored based on the member's health status/risk factors. Interactive implies a response mechanism that results in calibration of subsequent interventions. This category does not include searchable static web information. (Documentation needed)		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Self-initiated text/email messaging		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Interactive IVR with information capture Answer “Interactive IVR with information capture” only if it involves information capture		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

of member response information for record updates and/or triggering additional intervention.							
IVR with outbound messaging only		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE
Live outbound telephonic coaching program (count only members that are successfully engaged)		AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

6.3.3 If the plan indicates that it monitors services for gaps in CAD and/or diabetes in questions above (Q 6.3.1 and/or 6.3.2), indicate which services are monitored. If the "other" choice is selected, describe the service that is monitored in the text box. The Plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

	Services Monitored	**Data Source in general, not per service**
CAD	*Multi, Checkboxes.* 1: Blood pressure levels, 2: Beta Blocker Use, 3: LDL testing, 4: LDL control, 5: Aspirin therapy, 6: Gaps in Rx fills, 7: Other, 8: Not monitored	*Multi, Checkboxes.* 1: Medical records, 2: Claim feed, 3: RX Data Feed, 4: Vendor feed (lab, x-ray), 5: Patient Self-Report, 6: Patient home monitoring
Diabetes	*Multi, Checkboxes.* 1: Retinal Exam, 2: LDL Testing, 3: LDL Control, 4: Foot exams, 5: Nephropathy testing, 6: HbA1c Control, 7: Blood pressure (130/80), 8: Blood pressure (140/90), 9: Gaps in Rx fills, 10: Other, 11: Not monitored	*Multi, Checkboxes.* 1: Medical records, 2: Claim feed, 3: RX Data Feed, 4: Vendor feed (lab, x-ray), 5: Patient Self-Report, 6: Patient home monitoring

6.3.4 If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events in the questions above (Q 6.3.1 and/or 6.3.2), provide an actual, blinded copy of the reminders or telephone scripts as DM 1a, 1b, 1c (if applicable). If the mailing/telephone script(s) does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service or Rx refill, please provide further evidence that the reminder targeted members who were

due or overdue for the service. Check the boxes below to indicate the disease states illustrated in the reports and whether the reminders addressed more than one service element (e.g., LDL and HbA1c tests for diabetics).

Multi, Checkboxes.
1: DM 1 is provided - Coronary Artery Disease,
2: DM 1 is provided - Diabetes,
3: No support is provided

6.3.5 If online interactive self-management support is offered (Q 6.3.1 and/or 6.3.2), provide screen prints or other documentation illustrating functionality as DM 2. Check the boxes below to indicate the disease states illustrated.

Multi, Checkboxes.
1: DM 2 is provided - Coronary Artery Disease,
2: DM 2 is provided - Diabetes,
3: No support is provided

6.3.6 Identify action(s) taken when individuals are identified with poor medication adherence through routine monitoring of refill activity. What is the scope of the program (entity that is primarily responsible for monitoring and action*) and which members are monitored)) and to whom are reminders and alerts directed? Exclude knowledge of medication gaps that are discovered in the course of telephonic outreach, such as might be the case for a disease management program. Include the responsible parties carrying out the reminders/calls/alerts (pharmacy, manufacturer,, etc.) Check all that apply.

*If “other” is a department within the plan that monitors and acts - please respond “plan personnel.” Primary party is the party who is responsible for the record of member on medication. Note that medication adherence refers to ongoing compliance taking medications that have been filled at least once. These lists are not intended to be exhaustive. If your plan targets other medications, takes other actions, etc., please describe them in the column provided. Interventions to encourage initiation of appropriate pharmacotherapy do not apply.

	Drugs Monitored for Adherence	**Primary party responsible for monitoring and acting on medication adherence**	**Members monitored**	**Actions taken**	**Other (describe)**
CAD	*Multi, Checkboxes.* 1: Statins, 2: Beta Blockers, 3: Nitrates, 4: Calcium Channel blockers, 5: ACEs/ARBs, 6: Other (describe), 7: Compliance (medication refills) is not systematically assessed	*Single, Radio group.* 1: Plan personnel, 2: PBM, 3: Retail or mail pharmacy, 4: Other (describe)	*Single, Radio group.* 1: All members taking the checked drugs are monitored, 2: Only DM participants are monitored	*Multi, Checkboxes.* 1: Member must activate reminders, 2: Member receives mailed reminders, 3: Member receives electronic reminder (e.g. email), 4: Member receives telephone contact, 5: Practitioner is mailed an alert, 6: Practitioner is contacted electronically, 7: Practitioner is contacted by telephone, 8: Telephonic coach is notified, 9: Gap in fills are communicated electronically to personal health record which will trigger a member alert, 10: Other (describe)	*200 words.*
Diabetes	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

6.3.7 (6.3.9) For members already participating in the telephone management program (beyond the initial contact) indicate the events that will cause the Plan to call a member outside of the standard schedule for calls. Check all that apply. Please note this refers only to members already participating in the telephone management program.

	Response
Coronary Artery Disease	*Multi, Checkboxes.* 1: Calls are made according to a set schedule only, 2: Clinical findings (e.g. lab results), 3: Acute event (e.g. ER, inpatient), 4: Medication events (e.g. failure to refill, excess use, drug/drug or drug/DX interaction), 5: Missed services (e.g. lab tests, office visits), 6: Live outbound telephone management is not offered
Diabetes	AS ABOVE

6.3.8 (6.3.10) Indicate the member support elements used in the Plan's live outbound telephone management program. Only select member support items that are both tracked and reportable to the purchaser. Check all that apply.

	Response
Coronary Artery Disease	*Multi, Checkboxes.* 1: Patient knowledge (e.g. patient activation measure score), 2: Interaction with caregivers such as family members (frequency tracked), 3: Goal attainment status, 4: Readiness to change score, 5: Care plan development, tracking, and follow-up, 6: Self-management skills, 7: Provider steerage, 8: Live outbound telephone management not offered, 9: Live outbound telephone management program offered but elements not tracked for reporting to purchaser
Diabetes	AS ABOVE

6.4 (6.5) Performance Measurement: CAD

Additional information not addressed elsewhere within this section can be provided in Section 6.7.

6.4.1 (6.5.1) Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2012 and QC 2011.The HEDIS measure eligible for rotation for QC 2012 is Controlling High Blood Pressure for CAD patients.

If plan rotated Controlling High Blood Pressure for CAD patients for QC 2012, QC 2012 would be based on QC 2011, so the prior year data that would be uploaded would be QC 2010.

If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	HMO QC 2012	HMO QC 2011, or Prior Year Results for rotated measure
Controlling High Blood Pressure – Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Persistence of Beta-Blocker treatment after a heart attack	AS ABOVE	AS ABOVE
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	AS ABOVE	AS ABOVE
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	AS ABOVE	AS ABOVE

6.4.2 (6.5.2) PPO VERSION OF ABOVE

6.5 (6.6) Performance Measurement: Diabetes

Additional information not addressed elsewhere within this section can be provided in Section 6.7.

6.5.1 (6.6.1) Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2012 and QC 2011
If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded),etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer may be auto-populated.

	HMO QC 2012 results	HMO QC 2011 or Prior Year for Rotated measures
Comprehensive Diabetes Care - Eye Exams	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Comprehensive Diabetes Care - HbA1c Testing	AS ABOVE	AS ABOVE

Comprehensive Diabetes Care - LDL-C Screening	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - Medical Attention for Nephropathy	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - Poor HbA1c Control > 9%	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 8%	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - HbA1c Control < 7%	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - LDL-C Controlled (LDL-C<100 mg/dL)	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	AS ABOVE	AS ABOVE
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	AS ABOVE	AS ABOVE

6.5.2 (6.6.2) PPO VERSION OF ABOVE

6.6 (6.7) Performance Measurement: Other Conditions

Additional information not addressed elsewhere within this section can be provided in Section 6.7.

6.6.1 (6.7.1) Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2012 and QC 2011. This was not a rotated measure.

This answer may be auto-populated.

	HMO QC 2012	**HMO QC 2011**
COPD: Use of Spirometry Testing in the Assessment and Diagnosis of COPD	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

6.6.2 (6.7.2) PPO VERSION OF ABOVE

6.6.3 (6.7.3) Review the two most recently uploaded years of HEDIS results for the Plan HMO product based on QC 2012 and QC 2011. This was not a rotated measure.

This answer may be auto-populated.

	HMO QC 2012	**HMO QC 2011**
Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

6.6.4 (6.7.4) PPO VERSION OF ABOVE

6.7 (6.8) Other Information

6.7.1 (6.8.1) If the Plan would like to include additional information about the disease management programs that was not reflected in this section, provide as DM 6.

7 Behavioral Health

7.1 Instructions

7.1.1 You may rely on o the "General Background and Process Directions" document for background, process and response instructions that apply across the 2013 eValue8 RFI.. The “General Background and Process Directions” document can be found at:

http://www.healthexchange.ca.gov/Solicitations/Documents/ev8_2013_Background_and_Process_Directions_11_14_2012.pdf

7.1.2 All attachments to this module must be labeled as "BH #" and submitted electronically. Where more than one document will be submitted in response to a request for an Attachment, label it as BH 1a, BH 1b, etc.

7.1.3 The Plan is asked to provide the information in this module for BOTH its contracted 1) Non-Behavioral Health Practitioners and Facilities and for 2) Behavioral Health Practitioners and Facilities. Non-Behavioral Health Practitioners and Facilities are defined as practitioners whose primary responsibility is NOT the delivery of behavioral health services (e.g., family practice physicians, internal medicine physicians, OB/GYN physicians, multi-specialty hospitals, etc.). Behavioral Health Practitioners and Facilities are defined as practitioners whose primary responsibility is the delivery of behavioral health services (e.g., psychiatrists, clinical psychologists, MSWs, alcohol inpatient treatment centers, etc.).

7.1.4 The Plan is asked to describe its behavioral health program organization, including the use of outside vendors. Plans that use vendors for behavioral health management should coordinate their answers with their vendor.

7.1.5 Behavioral Health is abbreviated as BH. AOD references the Alcohol and Other Drugs HEDIS measure. Managed Behavioral Health Organization is abbreviated as MBHO.

7.1.6 All responses for the 2013 RFI should reflect commercial HMO/POS and/or PPO plans. HMO and PPO responses are being collected in the same RFI template. In addition, where HEDIS or CAHPS data, or plan designed performance indicators are reported, one market must be identified as the reporting level (see Profile Section 3 questions) and used consistently throughout the 2013 RFI response. For HEDIS and CAHPS, the responses have been autopopulated but information should be reviewed. To activate the appropriate HMO and/or PPO questions in this template, please answer the question in 1.1.5

7.1.7 In general, Plan activities must be in place by the date of this RFI submission for credit to be awarded.

7.2 Plan Organization

Additional information not addressed elsewhere within this section can be provided in Section 7.5.

7.2.1 Identify how members are able to access BH services. Check all that apply.

Multi, Checkboxes.

1: BH practitioners are listed in the Plan's print/online directory,
2: Members call the Plan to identify an appropriate practitioner,
3: Members call the MBHO to identify an appropriate practitioner,
4: Members call the BH practitioner office directly,
5: Other (describe in detail box below):,
6: Not applicable/all BH services are carved out by the employers

7.2.2 What provisions are in place for members who contact the Plan's published BH service access line (member services or BH/MBHO department directly) for emergent BH services after regular business hours? For access to Behavioral Health clinical services, a "warm transfer" is defined as a telephone transfer by a Plan representative where the Plan representative ensures the member is connected to a live voice in the Behavioral Health Department or at the Behavioral Health vendor without interruption or the need to call back. Check all that apply.

Multi, Checkboxes.

1: Members reach a BH clinician directly,
2: Members reach a live response from a nurse or other triage trained individual and receive a warm transfer to a BH clinician,
3: Members reach an answering service or a message that provides the opportunity to receive a return call or to page a BH clinician,
4: Other (describe in detail box below):,
5: Not applicable/all BH services are carved out

7.2.3 Purchasers are interested in Plan activities in alcohol and depression screening and interventions. Indicate the scope of the Plan's Alcohol Use Disorder and Depression Programs. Alcohol screening is defined as the use of a valid questionnaire about the context, frequency and amount of an individual's alcohol use. Screening offers a reliable, inexpensive and quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one. Check all that apply.

If response options # 3 (All members actively involved in other disease management or case management programs) and # 4 (All members with targeted chronic disease conditions regardless of prior DM or case management program involvement (medium or low risk) are selected - please describe in following column.

If "program not available" is selected for all rows the following question asking about reach of programs will not be answerable.

	Response	**Description of programs and/or targeted conditions (response options 3 and 4 from previous column)**
Alcohol Screening	*Multi, Checkboxes.* 1: All members involved in the Plan's high risk pregnancy program, 2: All members who are pregnant (discovered through precertification, claims scanning,	*100 words.*

	medical records), 3: All members actively involved in other disease management or case management programs, 4: All members with targeted chronic disease conditions regardless of prior DM or case management program involvement (medium or low risk), 5: All members with medical record or claims indications of alcohol use or depression (e.g. antidepressant Rx), 6: All members (e.g. monitoring and following up on screening tools in medical record), 7: Other, 8: Program not available	
Alcohol Use Disorder Management	AS ABOVE	AS ABOVE
Depression Screening	AS ABOVE	AS ABOVE
Depression Management	AS ABOVE	AS ABOVE

7.2.4 For the commercial book of business, indicate the reach of the Plan's behavioral health screening and management program. If condition is only managed as a comorbidity within another program, the Plan should indicate the condition is managed only as a comorbidity and identify (as text in the last column) the primary condition(s) linked to the comorbidity. The distinction "available to all" versus "an option to purchase" should be provided only for these primary managed conditions where the Plan proactively identifies all members with the condition for program interventions - not just among these who have been identified with another condition (not comorbidity managed conditions). If the program is administered fully or jointly indicate the vendor name.

Alcohol screening is defined as the use of a valid questionnaire about the context, frequency and amount of an individual's alcohol use. Screening offers a reliable, inexpensive and quick way to identify individuals whose drinking patterns indicate that they have an alcohol problem or are at risk for developing one.

If response for column "Reach of disease management programs offered" differs based on product offered (HMO versus PPO) and plan is responding for BOTH products - please select the option that covers most of the membership (most common) and note the other in the additional information section.

	Reach of Programs	**Cost of Program availability**	**Vendor Name if plan outsources or jointly administers**
Alcohol Screening	*Single, Radio group.* 1: Available in all markets including this one, 2: Available only in specific markets including this one, 3: Available only in specific markets BUT NOT this one	*Multi, Checkboxes.* 1: Plan-wide, condition-specific and available to all fully insured members as described in question above as part of standard premium, 2: Plan-wide, condition-specific and available to all self-insured members as described in question above as part of standard ASO fee with no additional fee assessed, 3: Employer option to purchase for additional fee for fully insured members, 4: Employer option to purchase for additional fee for self-insured members.	*50 words.*
Alcohol Use Disorder Management	AS ABOVE	AS ABOVE	AS ABOVE

Depression Screening	AS ABOVE	AS ABOVE	AS ABOVE
Depression Management	AS ABOVE	AS ABOVE	AS ABOVE

7.3 Member Screening & Support

Additional information not addressed elsewhere within this section can be provided in Section 7.5.

7.3.1 (7.3.4) If the Plan indicated member-specific reminders for known gaps in clinical/diagnostic maintenance service and/or medication events, provide an actual, blinded copy of the reminder as BH 2. If the reminder does not specifically indicate that the member was identified for the reminder as a result of a gap in a recommended service, please provide further evidence that the reminder targeted members who were due or overdue for the service. Check the boxes below to indicate the disease states illustrated in the reports and whether the reminders addressed more than one service element. If the plan indicates that it monitors services for gaps, indicate which services are monitored. If the "other" choice is selected, describe the service that is monitored in the text box. The Plan can also use this text box to describe their general approach to reminders, such as criteria to distinguish which members are given member-specific reminders.

Multi, Checkboxes.
1: BH 2 is provided - Behavioral health,
2: BH 2 is provided - Substance use,
3: Not provided

7.3.2 (7.3.5) Identify action(s) taken when individuals are identified with poor medication adherence through routine monitoring of refill activity. What is the scope of the program (entity that is primarily responsible for monitoring and action* and which members are monitored) and to whom are reminders and alerts directed? Exclude knowledge of medication gaps that are discovered in the course of telephonic outreach, such as might be the case for a disease management program. Include the responsible parties carrying out the reminders/calls/alerts (pharmacy, manufacturer, Plan, etc.) Check all that apply.

*If "other" is a department within the plan that monitors and acts – please respond "plan personnel." Primary party is the party who is responsible for the record of member on medication. Note that medication adherence refers to ongoing compliance taking medications that have been filled at least once. These lists are not intended to be exhaustive. If your plan targets other medications, takes other actions, etc., please describe them in the column provided. Interventions to encourage initiation of appropriate pharmacotherapy do not apply.

	Drugs that are monitored for adherence	**Primary party responsible for monitoring and acting on adherence**	**Members monitored**	**Actions taken**	**Other (describe) Action Taken and/or Responsible Party**
Behavioral Health	*Multi, Checkboxes.* 1: Antidepressants, 2: Atypical antipsychotics,	*Single, Pull-down list.* 1: Plan personnel, 2: PBM,	*Single, Radio group.* 1: All members taking the checked drugs	*Multi, Checkboxes.* 1: Member must activate reminders, 2: Member receives mailed	*200 words.*

	3: Other (describe), 4: Compliance (medication refills) is not systematically assessed	3: Retail or mail pharmacy, 4: Other (describe)	are monitored, 2: Only DM participants are monitored	reminders, 3: Member receives electronic reminder (e.g. email), 4: Member receives telephone contact, 5: Practitioner is mailed an alert, 6: Practitioner is contacted electronically, 7: Practitioner is contacted by telephone, 8: Telephonic coach is notified, 9: Gap in fills are communicated electronically to personal health record which will trigger a member alert, 10: Other (describe)	
Substance Use	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE	AS ABOVE

7.4 (7.5) Performance Results

Additional information not addressed elsewhere within this section can be provided in Section 7.5.

7.4.1 (7.5.1) Review the two most recently calculated years of HEDIS results for the Plan's HMO Product. Measures not eligible for rotation in QC 2012. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value, instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded), etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

	QC 2012 result	QC 2011 result
Identification of Alcohol & Other Drug Dependence Services - % Members Receiving Any Services	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.

7.4.2 (7.5.2) PPO VERSION OF ABOVE

7.4.3 (7.5.3) Review the two most recently calculated years of HEDIS results for the Plan's HMO product. Measures not eligible for rotation in QC 2012. If a plan did not report a certain measure to Quality Compass (QC), or NCQA chose to exclude a certain value,

instead of a rate, QC may have codes such as NR (not reported), EXC (Excluded),etc. To reflect this result in a numeric form for uploading, the following coding was devised:

-1 means 'NR'
-2 means 'NA'
-3 means 'ND' and
-4 means 'EXC'

This answer is auto-populated.

	QC 2012result	QC 2011result
Mental Health Utilization - % Members Receiving Services - Any	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
FU After Hospitalization For Mental Illness - 7 days	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
FU After Hospitalization For Mental Illness - 30 days	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Antidepressant Medication Management - Effective Acute Phase Treatment	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Antidepressant Medication Management - Effective Continuation Phase Treatment	*Percent.* From -10 to 100.	*Percent.* From -10 to 100.
Follow up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	*Decimal.* From -10 to 100.	*Decimal.* From -10 to 100.
Follow Up Care for Children Prescribed ADHD Medication - Initiation	*Decimal.* From -10 to 100.	*Decimal.* From -10 to 100.

7.4.4 (7.5.4) PPO VERSION OF ABOVE

7.5 (7.6) Other Information

7.5.1 (7.6.1) If the Plan would like to provide additional information about the BH program that was not reflected in this section, provide as BH 5.

III. PROPOSAL PREPARATION INSTRUCTIONS

A. INTRODUCTION

This section provides instructions for preparation of the Bidder's response to the requirements of the Selection Criteria as well as the requirements for the response to administrative requirements, format, assembly and packaging of responses.

B. ADDITIONAL QUESTIONS SUBMISSION: REGULATORY, QHP, EXCHANGE AND OTHER

This subsection addresses the portions of the response content submitted electronically. Bidders must submit answers to all questions electronically.

C. FINAL RESPONSE FORMAT AND CONTENT

These instructions describe the mandatory response format and the required approach for the development and presentation of response data. Format instructions must be adhered to, all requirements and questions in the solicitation must be responded to, and all requested data must be supplied.

The Exchange intends to make the entirety of this solicitation available electronically at https://www.proposaltech.com/app.php/login. QHP Bidders, identified through the Notice of Intent to Bid process, will be assigned a login identification. Each QHP Bidder will be required to identify a primary solicitation respondent but that individual may, in turn, designate internal subject matter experts for responding. QHP Bidders will participate in two training sessions conducted by the Exchange and will receive written documentation in support of their use of the website portal where the QHP solicitation is accessed for response. The Exchange will provide support to QHP Bidders during the response period.

The Bidder must ensure its response is submitted in a manner that enables the Exchange Evaluation Team to easily locate response descriptions and exhibits for each requirement.

1. GENERAL INSTRUCTIONS

a. Each firm may submit only one response. For the purposes of this paragraph, "firm" includes a parent corporation of a firm and any other subsidiary of that parent corporation. If a firm submits more than one response, the Exchange will reject all responses submitted by that firm. Issuers who offer both DMHC and CDI regulated products (insurance policies and licensed Knox-Keene Plans) are considered a "firm" for bidding purposes. For example, Issuers should not submit the same PPO product under CDI jurisdiction and the same PPO under DMHC jurisdiction.

b. Develop responses by following all solicitation instructions and/or clarifications provided for reference purposes by the Exchange in the form of question and answer responses,

c. Before submitting a response, seek timely written clarification of any requirements or instructions that are believed to be vague, unclear or that

are not fully understood. These inquiries should be made during the timeframe outlined in the solicitation timeline except in emergencies.

d. In preparing a response, all narrative portions should be straightforward, detailed and precise, and shall be provided within the designated space requirements for each item. Limits will be set within the electronic format. The Exchange will determine the responsiveness of a proposal by its quality, not its quantity, volume, packaging or colored displays.

Detailed response instructions will be provided for your reference on the website portal set up for QHP Bidders' use in responding to the QHP solicitation.

All responses must be delivered to the Solicitation Official listed in Section J by the date and time listed in Section I, Key Action Dates for response submission.

IV. EVALUATION

A. INTRODUCTION

This section presents the evaluation process and scoring procedures the Exchange will follow in reviewing responses submitted in response to this solicitation.

Final Responses must be received by the Solicitation Official no later than the date and time specified in Section I, Key Action Dates. Late responses will be rejected.

The Exchange will appoint an Evaluation Team to conduct the response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the Response to Requirements.

Final selection will be on the basis of compliance with the proposal preparation requirements. Responses that are not responsive to the proposal preparation requirements may be deemed non-responsive and excluded from further consideration by the Exchange.

B. RECEIPT

Upon receipt, the internet web portal will date and time mark every response and verify that all responses are submitted under an appropriate cover, sealed, and properly identified. QHP Bidders will be asked to “lock” and “archive” their responses electronically through the website portal.

C. EVALUATION OF FINAL RESPONSES

During Final Response evaluation the Exchange Evaluation Team will check each response in detail to determine its compliance with the proposal preparation requirements. Failure to respond to and/or meet a mandatory requirement may result in the Final Response being considered non-responsive. The Evaluation Team will be responsible for determining whether such a failure exists and whether it is material or immaterial.

The Evaluation Team will be responsible for compiling and assessing the responses to the solicitation and the cost-bids to determine and make recommendations for the best mix of QHPs for each region to meet the overall guidelines described for QHP selection.

V. APPENDIX

APPENDIX I - ADMINISTRATIVE REQUIREMENTS FORMS

Addendum 1: Bidder Information Cover Page (due January 23, 2013)

APPENDIX II - SUPPLEMENTAL FORMS FOR RESPONSE TO SOLICITATION

Addendum 1: Geographic and Product Availability (due January 31, 2013)

1.1 - SHOP Rating Region by Plan Type

1.2 - Individual Exchange Rating Region by Plan Type

1.3 - SHOP Product Design by Region

1.4 - Individual Product Design by Region

1.5 - Geographic Availability - Region-County-Zipcode Table (Submitted as an Excel attachment)

1.6 - Delivery System Reform Initiatives

1.7 - SHOP Alternate Plan Design

1.8 - Individual Alternate Plan Design

Addendum 2: Provider Network and Essential Community Providers (due February 15, 2013)

2.1 - Contracted Providers by County as of January 1, 2013 (Submitted as an Excel attachment)

2.2 - Contracted Facilities by County as of January 1, 2013 (Submitted as an Excel attachment)

2.3 - Number and Percent of Contracted 340B Providers by County for Standard Plan 1 (Copay)

2.4 - Number and Percent of Contracted 340B Providers by County for Standard Plan 2 (Coinsurance)

2.5 - Number and Percent of Contracted 340B Providers by County for Catastrophic Plan

2.6 - Number and Percent of Contracted 340B Providers by County for HSA Plan

2.7 - Number and Percent of Contracted 340B Providers by County for Alternate Plan

Addendum 3: **Standard Benefit Plan Design Formats** (TO BE ISSUED THROUGH A FUTURE ADMINISTRATIVE RULEMAKING)

Addendum 4: Premium Bid Formats (TO BE ISSUED THROUGH A FUTURE ADMINISTRATIVE RULEMAKING)

Premium/Bid Table by Product

Interest in Multi-Year Contract by Rating Region

Premium/Bid Table (Standalone Dental Plans)

Age Band Factors by Product

Family Tier Factors by Product

APPENDIX III - ADDITIONAL INFORMATION FOR BIDDERS

The following documents may be accessed at http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf

List of Essential Community Providers: 340B Providers

List of Essential Community Providers: California Medicaid Disproportionate Share Hospitals

List of Federally Designated 638 Tribal Health Programs and Title V Indian Health Programs

List of Essential Community Providers: Section 1204c Community Clinic providers

List of Providers with Approved Applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program

Map/Plotting of Essential Community Providers by County Map/Plotting of Low Income (200% FPL and below) Population by County

Please refer to Attachments for individual forms.

VI. ACRONYMS

The following is a list of acronyms used in the QHP Solicitation.

ACA	Affordable Care Act
ACO	Accountable Care Organization
AF4Q	Aligning Forces for Quality
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
AMI	Acute Myocardial Infarction
AOC	Alcohol and Other Drugs
APCD	All-Payer Claims Database
BMI	Body Mass Index
CA-ACA	California Patient Protection and Affordable Care Act
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CalHEERS	California Healthcare Eligibility, Enrollment & Retention System
CDI	California Department of Insurance
CHART	California Hospital Assessment and Reporting Taskforce
CHCF	California Healthcare Foundation
COE	Centers of Excellence
CPOE	Computerized Provider Order Entry
CPR	Catalyst for Payment Reform
CY	Calendar Year
DM	Disease Management
DMHC	Department of Managed Health Care
DOFR	Division of Financial Responsibility
EBM	Evidence Based Medicine
ECP	Essential Community Providers
EOC	Episode of Care
EPO	Exclusive Provider Organization
ESAs	Erythropoiesis-Stimulating Agents
Exchange	California Health Benefit Exchange
FDA	Federal Drug Administration
FFS	Fee For Service
FU	Follow Up
HA	Health Assessment
HACs	Healthcare Acquired Conditions (also known as Hospital-Acquired Conditions)
HSA	Health Savings Account
HF	Heart Failure
HIPDB	Healthcare Integrity and Protection Data Bank
HMO	Health Maintenance Organization
HRA	Health Risk Assessment
ICU	Intensive Care Unit

IHA	Integrated Healthcare Association
IHM	Integrated Healthcare Model
LHRP	Leapfrog's Health Plan Performance Dashboard
MS	Multiple Sclerosis
NICU	Neonatal Intensive Care
NQF	National Quality Forum
NR	Not Reported
NRT	Nicotine Replacement Therapy
OTC	Over the Counter
P4P	Pay for Performance
PBM	Pharmacy Benefit Manager
PCMH	Patient-Centered Medical Home
PCR	Plan All Cause Readmission
PHQ	Physician and Hospital Quality (a certification offered by NCQA)
PHR	(Electronic) Personal Health Record
PMPM	Per Member Per Month
PMPY	Per Member Per Year
PNE	Pneumonia
POS	Point of Service
PPO	Preferred Provider Organization
PQA	Pharmacy Quality Alliance
PQRS	Physician Quality Reporting System
QC	Quality Compass
QHP	Qualified Health Plan
QI	Quality Indicator
QIPs	Quality Improvement Projects
RFI	Request for Information
SCIP	Surgical Care Improvement Project
SHOP	Small Business Health Options Program
SIP	Surgical Infection Prevention
SP	Specialty Pharmaceuticals
SRE	Serious Reportable Events
TNF	(TNF Inhibitors) Tumor Necrosis Factor
UCR	Usual, Customary and Reasonable
UTI	Urinary Tract Infection
VBAC	Vaginal Birth After Cesarean
WBC	White Blood Cell

This page intentionally left blank

Bidder Information Cover Page

Bidders must sign this Cover Page for the Exchange QHP Solicitation submission to be complete.

Due with complete Exchange QHP Solicitation response by
The Bidder's due date on January 23, 2013 5:00 pm PST
To be attached in eRFP question 2.1.1.1

Please complete the following:

Please provide the following information:	
NAIC Company Code	
NAIC Group Code	
Regulator(s)	[List regulator(s) to which Exchange product(s) will be submitted]
Federal Employer ID	
HIOS/Issuer ID	
Issuer Name	
Address	
City	
State	
ZIP	
Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	

I hereby certify that I have reviewed the information entered into the Proposal Tech website for the California Health Benefit Exchange and any corresponding attachments submitted in support of the response. Upon review and to the best of my knowledge the information provided is an accurate and complete representation of the activities and results for this Bidder and is not in any material way false, untrue, invalid or misleading.

The signatory should be of a senior official responsible for coordinating plan responses to this RFP.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

California Health Benefit Exchange QHP Solicitation

Appendix II, Addendum 1 Geographic and Product Availability

The following attachments are due January 31, 2013 at close of business.
Standard Benefit Plan designs , rating factors and age bands, will be released at a later date pending federal regulations and release of the final Federal Actuarial Value calculator and will be the subject of a future state rulemaking procedure.

Attachment
1.1 - SHOP Rating Region by Plan Type
1.2 - Individual Exchange Rating Region by Plan Type
1.3 - SHOP Product Design by Region
1.4 - Individual Product Design by Region
1.5 - Geographic Availability - Region-County-Zipcode Table *(Submitted as an Excel attachment)*
1.6 - Delivery System Reform Initiatives
1.7 - SHOP Alternate Plan Design
1.8 - Individual Alternate Plan Design

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 1, Attachment 1.1 - SHOP Rating Region by Plan Type

If an Issuer currently sells Small Group and Individual, the Issuer must respond for SHOP in order to bid for Individual. Selecting a box below means Issuer will submit a QHP Bid for the selected rating region for the selected or all metal tiers and a catastrophic benefit design within that rating region. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan or propose an Alternate Plan. The **19 regions** are defined based on recent California legislation and shown in the linked attachment. See attachment 1.5 for rating regions by zip codes.

	SHOP	SHOP	SHOP
Rating Region	**Standardized Plan 1 (copay) or Plan 2 (coinsurance)**	**HSA Plan**	**Alternate Plan**
	Single, Pull-down list Full Region Partial Region Not Offered	*Single, Pull-down list* Full Region Partial Region Not Offered	*Single, Pull-down list* Full Region Not Offered
Region 1			
Region 2			
Region 3			
Region 4			
Region 5			
Region 6			
Region 7			
Region 8			
Region 9			
Region 10			
Region 11			
Region 12			
Region 13			
Region 14			
Region 15			
Region 16			
Region 17			
Region 18			
Region 19			
Total Regions			

Appendix II, Addendum 1, Attachment 1.2 - Individual Exchange Rating Region by Plan Type

	Individual	Individual	Individual
Rating Region	**Standardized Plan 1 (copay) or Plan 2 (coinsurance)**	**HSA Plan**	**Alternate Plan 1**
	Single, Pull-down list Full Region Partial Region Not Offered	*Single, Pull-down list* Full Region Partial Region Not Offered	*Single, Pull-down list* Full Region Not Offered
Region 1			
Region 2			
Region 3			
Region 4			
Region 5			
Region 6			
Region 7			
Region 8			
Region 9			
Region 10			
Region 11			
Region 12			
Region 13			
Region 14			
Region 15			
Region 16			
Region 17			
Region 18			
Region 19			
Total Regions			

California Health Benefit Exchange
Qualified Health Plans Solicitation
Appendix II, Addendum 1, Attachment 1.3 - SHOP Product Design by Region

Indicate the metal levels by Standardized Plan Type. Issuer must offer a complete array of metal tiers and a catastrophic plan under either Standardized Plan 1 or 2, or the combined options, in order to submit an HSA Plan or propose an Alternate Plan. The **19 regions** are defined based on recent California legislation and shown in the linked attachment .See attachment 1.5 for rating regions by zip codes.

	SHOP	SHOP	SHOP	SHOP
Rating Region	**Standardized Plan 1 (Copay)**	**Standardized Plan 2 (Coinsurance)**	**HSA Plan**	**Alternate Plan**
Region 1	*Multi-choice* Platinum Gold Silver Bronze Catastrophic	*Multi-choice* Platinum Gold Silver Bronze Catastrophic	*Multi-choice* Silver Bronze	*Multi-choice* Platinum Gold Silver Bronze
Region 2				
Region 3				
Region 4				
Region 5				
Region 6				
Region 7				
Region 8				
Region 9				
Region 10				
Region 11				
Region 12				
Region 13				
Region 14				
Region 15				
Region 16				
Region 17				
Region 18				
Region 19				
Total Regions				

Appendix II, Addendum 1, Attachment 1.4 - Individual Product Design by Region

	Individual	Individual	Individual	Individual
Rating Region	**Standardized Plan 1 (Copay)**	**Standardized Plan 2 (Coinsurance)**	**HSA Plan**	**Alternate Plan**
Region 1	*Multi-choice* Platinum Gold Silver Bronze Catastrophic	*Multi-choice* Platinum Gold Silver Bronze Catastrophic	*Multi-choice* Silver Bronze	*Multi-choice* Platinum Gold Silver Bronze
Region 2				
Region 3				
Region 4				
Region 5				
Region 6				
Region 7				
Region 8				
Region 9				
Region 10				
Region 11				
Region 12				
Region 13				
Region 14				
Region 15				
Region 16				
Region 17				
Region 18				
Region 19				
Total Regions				

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 1, Attachment 1.5 - Zip Codes for Licensed Geographic Service Areas

NOTE: The Exchange has adopted the small group rating regions for both Individual and SHOP Exchanges.

Indicate "X" in each row designating the zip code in which the Bidder is offering coverage by that product type.

Issuer Name:

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
94501	ALAMEDA	Region 6												
94502	ALAMEDA	Region 6												
94536	ALAMEDA	Region 6												
94537	ALAMEDA	Region 6												
94538	ALAMEDA	Region 6												
94539	ALAMEDA	Region 6												
94540	ALAMEDA	Region 6												
94541	ALAMEDA	Region 6												
94542	ALAMEDA	Region 6												
94543	ALAMEDA	Region 6												
94544	ALAMEDA	Region 6												
94545	ALAMEDA	Region 6												
94546	ALAMEDA	Region 6												
94550	ALAMEDA	Region 6												
94551	ALAMEDA	Region 6												
94552	ALAMEDA	Region 6												
94555	ALAMEDA	Region 6												
94557	ALAMEDA	Region 6												
94560	ALAMEDA	Region 6												
94566	ALAMEDA	Region 6												
94568	ALAMEDA	Region 6												
94577	ALAMEDA	Region 6												
94578	ALAMEDA	Region 6												
94579	ALAMEDA	Region 6												
94580	ALAMEDA	Region 6												
94586	ALAMEDA	Region 6												
94587	ALAMEDA	Region 6												
94588	ALAMEDA	Region 6												
94601	ALAMEDA	Region 6												
94602	ALAMEDA	Region 6												
94603	ALAMEDA	Region 6												
94604	ALAMEDA	Region 6												
94605	ALAMEDA	Region 6												
94606	ALAMEDA	Region 6												
94607	ALAMEDA	Region 6												
94608	ALAMEDA	Region 6												
94609	ALAMEDA	Region 6												
94610	ALAMEDA	Region 6												
94611	ALAMEDA	Region 6												
94612	ALAMEDA	Region 6												
94613	ALAMEDA	Region 6												
94614	ALAMEDA	Region 6												
94615	ALAMEDA	Region 6												
94617	ALAMEDA	Region 6												
94618	ALAMEDA	Region 6												
94619	ALAMEDA	Region 6												
94620	ALAMEDA	Region 6												
94621	ALAMEDA	Region 6												
94622	ALAMEDA	Region 6												
94623	ALAMEDA	Region 6												
94624	ALAMEDA	Region 6												
94625	ALAMEDA	Region 6												
94649	ALAMEDA	Region 6												
94659	ALAMEDA	Region 6												
94660	ALAMEDA	Region 6												
94661	ALAMEDA	Region 6												
94662	ALAMEDA	Region 6												
94666	ALAMEDA	Region 6												
94701	ALAMEDA	Region 6												
94702	ALAMEDA	Region 6												
94703	ALAMEDA	Region 6												
94704	ALAMEDA	Region 6												
94705	ALAMEDA	Region 6												
94706	ALAMEDA	Region 6												
94707	ALAMEDA	Region 6												
94708	ALAMEDA	Region 6												
94709	ALAMEDA	Region 6												
94710	ALAMEDA	Region 6												
94712	ALAMEDA	Region 6												
94720	ALAMEDA	Region 6												
95646	ALPINE	Region 1												
96120	ALPINE	Region 1												
95601	AMADOR	Region 1												
95629	AMADOR	Region 1												
95640	AMADOR	Region 1												
95642	AMADOR	Region 1												
95644	AMADOR	Region 1												
95654	AMADOR	Region 1												
95665	AMADOR	Region 1												
95666	AMADOR	Region 1												
95669	AMADOR	Region 1												
95675	AMADOR	Region 1												
95685	AMADOR	Region 1												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95689	AMADOR	Region 1												
95699	AMADOR	Region 1												
95914	BUTTE	Region 1												
95916	BUTTE	Region 1												
95917	BUTTE	Region 1												
95926	BUTTE	Region 1												
95927	BUTTE	Region 1												
95928	BUTTE	Region 1												
95929	BUTTE	Region 1												
95930	BUTTE	Region 1												
95938	BUTTE	Region 1												
95940	BUTTE	Region 1												
95941	BUTTE	Region 1												
95942	BUTTE	Region 1												
95948	BUTTE	Region 1												
95954	BUTTE	Region 1												
95958	BUTTE	Region 1												
95965	BUTTE	Region 1												
95966	BUTTE	Region 1												
95967	BUTTE	Region 1												
95968	BUTTE	Region 1												
95969	BUTTE	Region 1												
95973	BUTTE	Region 1												
95974	BUTTE	Region 1												
95976	BUTTE	Region 1												
95978	BUTTE	Region 1												
95221	CALAVERAS	Region 1												
95222	CALAVERAS	Region 1												
95223	CALAVERAS	Region 1												
95224	CALAVERAS	Region 1												
95225	CALAVERAS	Region 1												
95226	CALAVERAS	Region 1												
95228	CALAVERAS	Region 1												
95229	CALAVERAS	Region 1												
95232	CALAVERAS	Region 1												
95233	CALAVERAS	Region 1												
95245	CALAVERAS	Region 1												
95246	CALAVERAS	Region 1												
95247	CALAVERAS	Region 1												
95248	CALAVERAS	Region 1												
95249	CALAVERAS	Region 1												
95250	CALAVERAS	Region 1												
95251	CALAVERAS	Region 1												
95252	CALAVERAS	Region 1												
95254	CALAVERAS	Region 1												
95255	CALAVERAS	Region 1												
95257	CALAVERAS	Region 1												
95912	COLUSA	Region 1												
95932	COLUSA	Region 1												
95950	COLUSA	Region 1												
95955	COLUSA	Region 1												
95970	COLUSA	Region 1												
95979	COLUSA	Region 1												
95987	COLUSA	Region 1												
94505	CONTRA COSTA	Region 5												
94506	CONTRA COSTA	Region 5												
94507	CONTRA COSTA	Region 5												
94509	CONTRA COSTA	Region 5												
94511	CONTRA COSTA	Region 5												
94513	CONTRA COSTA	Region 5												
94514	CONTRA COSTA	Region 5												
94516	CONTRA COSTA	Region 5												
94517	CONTRA COSTA	Region 5												
94518	CONTRA COSTA	Region 5												
94519	CONTRA COSTA	Region 5												
94520	CONTRA COSTA	Region 5												
94521	CONTRA COSTA	Region 5												
94522	CONTRA COSTA	Region 5												
94523	CONTRA COSTA	Region 5												
94524	CONTRA COSTA	Region 5												
94525	CONTRA COSTA	Region 5												
94526	CONTRA COSTA	Region 5												
94527	CONTRA COSTA	Region 5												
94528	CONTRA COSTA	Region 5												
94529	CONTRA COSTA	Region 5												
94530	CONTRA COSTA	Region 5												
94531	CONTRA COSTA	Region 5												
94547	CONTRA COSTA	Region 5												
94548	CONTRA COSTA	Region 5												
94549	CONTRA COSTA	Region 5												
94553	CONTRA COSTA	Region 5												
94556	CONTRA COSTA	Region 5												
94561	CONTRA COSTA	Region 5												
94563	CONTRA COSTA	Region 5												
94564	CONTRA COSTA	Region 5												
94565	CONTRA COSTA	Region 5												
94569	CONTRA COSTA	Region 5												
94570	CONTRA COSTA	Region 5												
94572	CONTRA COSTA	Region 5												
94575	CONTRA COSTA	Region 5												
94582	CONTRA COSTA	Region 5												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
94583	CONTRA COSTA	Region 5												
94595	CONTRA COSTA	Region 5												
94596	CONTRA COSTA	Region 5												
94597	CONTRA COSTA	Region 5												
94598	CONTRA COSTA	Region 5												
94801	CONTRA COSTA	Region 5												
94802	CONTRA COSTA	Region 5												
94803	CONTRA COSTA	Region 5												
94804	CONTRA COSTA	Region 5												
94805	CONTRA COSTA	Region 5												
94806	CONTRA COSTA	Region 5												
94807	CONTRA COSTA	Region 5												
94808	CONTRA COSTA	Region 5												
94820	CONTRA COSTA	Region 5												
94850	CONTRA COSTA	Region 5												
95531	DEL NORTE	Region 1												
95532	DEL NORTE	Region 1												
95538	DEL NORTE	Region 1												
95543	DEL NORTE	Region 1												
95548	DEL NORTE	Region 1												
95567	DEL NORTE	Region 1												
95613	EL DORADO	Region 3												
95614	EL DORADO	Region 3												
95619	EL DORADO	Region 3												
95623	EL DORADO	Region 3												
95633	EL DORADO	Region 3												
95634	EL DORADO	Region 3												
95635	EL DORADO	Region 3												
95636	EL DORADO	Region 3												
95651	EL DORADO	Region 3												
95656	EL DORADO	Region 3												
95664	EL DORADO	Region 3												
95667	EL DORADO	Region 3												
95672	EL DORADO	Region 3												
95682	EL DORADO	Region 3												
95684	EL DORADO	Region 3												
95709	EL DORADO	Region 3												
95720	EL DORADO	Region 3												
95721	EL DORADO	Region 3												
95726	EL DORADO	Region 3												
95735	EL DORADO	Region 3												
95762	EL DORADO	Region 3												
96142	EL DORADO	Region 3												
96150	EL DORADO	Region 3												
96151	EL DORADO	Region 3												
96152	EL DORADO	Region 3												
96154	EL DORADO	Region 3												
96155	EL DORADO	Region 3												
96156	EL DORADO	Region 3												
96157	EL DORADO	Region 3												
96158	EL DORADO	Region 3												
93210	FRESNO	Region 11												
93234	FRESNO	Region 11												
93242	FRESNO	Region 11												
93602	FRESNO	Region 11												
93605	FRESNO	Region 11												
93606	FRESNO	Region 11												
93607	FRESNO	Region 11												
93608	FRESNO	Region 11												
93609	FRESNO	Region 11												
93611	FRESNO	Region 11												
93612	FRESNO	Region 11												
93613	FRESNO	Region 11												
93616	FRESNO	Region 11												
93619	FRESNO	Region 11												
93621	FRESNO	Region 11												
93622	FRESNO	Region 11												
93624	FRESNO	Region 11												
93625	FRESNO	Region 11												
93626	FRESNO	Region 11												
93627	FRESNO	Region 11												
93628	FRESNO	Region 11												
93630	FRESNO	Region 11												
93631	FRESNO	Region 11												
93634	FRESNO	Region 11												
93640	FRESNO	Region 11												
93641	FRESNO	Region 11												
93642	FRESNO	Region 11												
93646	FRESNO	Region 11												
93648	FRESNO	Region 11												
93649	FRESNO	Region 11												
93650	FRESNO	Region 11												
93651	FRESNO	Region 11												
93652	FRESNO	Region 11												
93654	FRESNO	Region 11												
93656	FRESNO	Region 11												
93657	FRESNO	Region 11												
93660	FRESNO	Region 11												
93662	FRESNO	Region 11												
93664	FRESNO	Region 11												
93667	FRESNO	Region 11												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93668	FRESNO	Region 11												
93675	FRESNO	Region 11												
93701	FRESNO	Region 11												
93702	FRESNO	Region 11												
93703	FRESNO	Region 11												
93704	FRESNO	Region 11												
93705	FRESNO	Region 11												
93706	FRESNO	Region 11												
93707	FRESNO	Region 11												
93708	FRESNO	Region 11												
93709	FRESNO	Region 11												
93710	FRESNO	Region 11												
93711	FRESNO	Region 11												
93712	FRESNO	Region 11												
93714	FRESNO	Region 11												
93715	FRESNO	Region 11												
93716	FRESNO	Region 11												
93717	FRESNO	Region 11												
93718	FRESNO	Region 11												
93720	FRESNO	Region 11												
93721	FRESNO	Region 11												
93722	FRESNO	Region 11												
93723	FRESNO	Region 11												
93724	FRESNO	Region 11												
93725	FRESNO	Region 11												
93726	FRESNO	Region 11												
93727	FRESNO	Region 11												
93728	FRESNO	Region 11												
93729	FRESNO	Region 11												
93730	FRESNO	Region 11												
93740	FRESNO	Region 11												
93741	FRESNO	Region 11												
93744	FRESNO	Region 11												
93745	FRESNO	Region 11												
93747	FRESNO	Region 11												
93750	FRESNO	Region 11												
93755	FRESNO	Region 11												
93760	FRESNO	Region 11												
93761	FRESNO	Region 11												
93764	FRESNO	Region 11												
93765	FRESNO	Region 11												
93771	FRESNO	Region 11												
93772	FRESNO	Region 11												
93773	FRESNO	Region 11												
93774	FRESNO	Region 11												
93775	FRESNO	Region 11												
93776	FRESNO	Region 11												
93777	FRESNO	Region 11												
93778	FRESNO	Region 11												
93779	FRESNO	Region 11												
93780	FRESNO	Region 11												
93784	FRESNO	Region 11												
93786	FRESNO	Region 11												
93790	FRESNO	Region 11												
93791	FRESNO	Region 11												
93792	FRESNO	Region 11												
93793	FRESNO	Region 11												
93794	FRESNO	Region 11												
93844	FRESNO	Region 11												
93888	FRESNO	Region 11												
95913	GLENN	Region 1												
95920	GLENN	Region 1												
95939	GLENN	Region 1												
95943	GLENN	Region 1												
95951	GLENN	Region 1												
95963	GLENN	Region 1												
95988	GLENN	Region 1												
95501	HUMBOLDT	Region 1												
95502	HUMBOLDT	Region 1												
95503	HUMBOLDT	Region 1												
95511	HUMBOLDT	Region 1												
95514	HUMBOLDT	Region 1												
95518	HUMBOLDT	Region 1												
95519	HUMBOLDT	Region 1												
95521	HUMBOLDT	Region 1												
95524	HUMBOLDT	Region 1												
95525	HUMBOLDT	Region 1												
95526	HUMBOLDT	Region 1												
95528	HUMBOLDT	Region 1												
95534	HUMBOLDT	Region 1												
95536	HUMBOLDT	Region 1												
95537	HUMBOLDT	Region 1												
95540	HUMBOLDT	Region 1												
95542	HUMBOLDT	Region 1												
95545	HUMBOLDT	Region 1												
95546	HUMBOLDT	Region 1												
95547	HUMBOLDT	Region 1												
95549	HUMBOLDT	Region 1												
95550	HUMBOLDT	Region 1												
95551	HUMBOLDT	Region 1												
95553	HUMBOLDT	Region 1												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95554	HUMBOLDT	Region 1												
95555	HUMBOLDT	Region 1												
95556	HUMBOLDT	Region 1												
95558	HUMBOLDT	Region 1												
95559	HUMBOLDT	Region 1												
95560	HUMBOLDT	Region 1												
95562	HUMBOLDT	Region 1												
95564	HUMBOLDT	Region 1												
95565	HUMBOLDT	Region 1												
95569	HUMBOLDT	Region 1												
95570	HUMBOLDT	Region 1												
95571	HUMBOLDT	Region 1												
95573	HUMBOLDT	Region 1												
95589	HUMBOLDT	Region 1												
92222	IMPERIAL	Region 13												
92227	IMPERIAL	Region 13												
92231	IMPERIAL	Region 13												
92232	IMPERIAL	Region 13												
92233	IMPERIAL	Region 13												
92243	IMPERIAL	Region 13												
92244	IMPERIAL	Region 13												
92249	IMPERIAL	Region 13												
92250	IMPERIAL	Region 13												
92251	IMPERIAL	Region 13												
92257	IMPERIAL	Region 13												
92259	IMPERIAL	Region 13												
92266	IMPERIAL	Region 13												
92273	IMPERIAL	Region 13												
92275	IMPERIAL	Region 13												
92281	IMPERIAL	Region 13												
92283	IMPERIAL	Region 13												
92328	INYO	Region 13												
92384	INYO	Region 13												
92389	INYO	Region 13												
93513	INYO	Region 13												
93514	INYO	Region 13												
93515	INYO	Region 13												
93522	INYO	Region 13												
93526	INYO	Region 13												
93530	INYO	Region 13												
93542	INYO	Region 13												
93545	INYO	Region 13												
93549	INYO	Region 13												
93203	KERN	Region 14												
93205	KERN	Region 14												
93206	KERN	Region 14												
93215	KERN	Region 14												
93216	KERN	Region 14												
93220	KERN	Region 14												
93222	KERN	Region 14												
93224	KERN	Region 14												
93225	KERN	Region 14												
93226	KERN	Region 14												
93238	KERN	Region 14												
93240	KERN	Region 14												
93241	KERN	Region 14												
93243	KERN	Region 14												
93249	KERN	Region 14												
93250	KERN	Region 14												
93251	KERN	Region 14												
93252	KERN	Region 14												
93255	KERN	Region 14												
93263	KERN	Region 14												
93268	KERN	Region 14												
93276	KERN	Region 14												
93280	KERN	Region 14												
93283	KERN	Region 14												
93285	KERN	Region 14												
93287	KERN	Region 14												
93301	KERN	Region 14												
93302	KERN	Region 14												
93303	KERN	Region 14												
93304	KERN	Region 14												
93305	KERN	Region 14												
93306	KERN	Region 14												
93307	KERN	Region 14												
93308	KERN	Region 14												
93309	KERN	Region 14												
93311	KERN	Region 14												
93312	KERN	Region 14												
93313	KERN	Region 14												
93314	KERN	Region 14												
93380	KERN	Region 14												
93383	KERN	Region 14												
93384	KERN	Region 14												
93385	KERN	Region 14												
93386	KERN	Region 14												
93387	KERN	Region 14												
93388	KERN	Region 14												
93389	KERN	Region 14												
93390	KERN	Region 14												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93501	KERN	Region 14												
93502	KERN	Region 14												
93504	KERN	Region 14												
93505	KERN	Region 14												
93516	KERN	Region 14												
93518	KERN	Region 14												
93519	KERN	Region 14												
93523	KERN	Region 14												
93524	KERN	Region 14												
93527	KERN	Region 14												
93528	KERN	Region 14												
93531	KERN	Region 14												
93554	KERN	Region 14												
93555	KERN	Region 14												
93556	KERN	Region 14												
93560	KERN	Region 14												
93561	KERN	Region 14												
93581	KERN	Region 14												
93596	KERN	Region 14												
93202	KINGS	Region 11												
93204	KINGS	Region 11												
93212	KINGS	Region 11												
93230	KINGS	Region 11												
93232	KINGS	Region 11												
93239	KINGS	Region 11												
93245	KINGS	Region 11												
93246	KINGS	Region 11												
93266	KINGS	Region 11												
95422	LAKE	Region 1												
95423	LAKE	Region 1												
95424	LAKE	Region 1												
95426	LAKE	Region 1												
95435	LAKE	Region 1												
95443	LAKE	Region 1												
95451	LAKE	Region 1												
95453	LAKE	Region 1												
95457	LAKE	Region 1												
95458	LAKE	Region 1												
95461	LAKE	Region 1												
95464	LAKE	Region 1												
95467	LAKE	Region 1												
95485	LAKE	Region 1												
95493	LAKE	Region 1												
96009	LASSEN	Region 1												
96068	LASSEN	Region 1												
96109	LASSEN	Region 1												
96113	LASSEN	Region 1												
96114	LASSEN	Region 1												
96117	LASSEN	Region 1												
96119	LASSEN	Region 1												
96121	LASSEN	Region 1												
96123	LASSEN	Region 1												
96127	LASSEN	Region 1												
96128	LASSEN	Region 1												
96130	LASSEN	Region 1												
96132	LASSEN	Region 1												
96136	LASSEN	Region 1												
96137	LASSEN	Region 1												
90001	LOS ANGELES	Region 16												
90002	LOS ANGELES	Region 16												
90003	LOS ANGELES	Region 16												
90004	LOS ANGELES	Region 16												
90005	LOS ANGELES	Region 16												
90006	LOS ANGELES	Region 16												
90007	LOS ANGELES	Region 16												
90008	LOS ANGELES	Region 16												
90009	LOS ANGELES	Region 16												
90010	LOS ANGELES	Region 16												
90011	LOS ANGELES	Region 16												
90012	LOS ANGELES	Region 16												
90013	LOS ANGELES	Region 16												
90014	LOS ANGELES	Region 16												
90015	LOS ANGELES	Region 16												
90016	LOS ANGELES	Region 16												
90017	LOS ANGELES	Region 16												
90018	LOS ANGELES	Region 16												
90019	LOS ANGELES	Region 16												
90020	LOS ANGELES	Region 16												
90021	LOS ANGELES	Region 16												
90022	LOS ANGELES	Region 16												
90023	LOS ANGELES	Region 16												
90024	LOS ANGELES	Region 16												
90025	LOS ANGELES	Region 16												
90026	LOS ANGELES	Region 16												
90027	LOS ANGELES	Region 16												
90028	LOS ANGELES	Region 16												
90029	LOS ANGELES	Region 16												
90030	LOS ANGELES	Region 16												
90031	LOS ANGELES	Region 16												
90032	LOS ANGELES	Region 16												
90033	LOS ANGELES	Region 16												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
90034	LOS ANGELES	Region 16												
90035	LOS ANGELES	Region 16												
90036	LOS ANGELES	Region 16												
90037	LOS ANGELES	Region 16												
90038	LOS ANGELES	Region 16												
90039	LOS ANGELES	Region 16												
90040	LOS ANGELES	Region 16												
90041	LOS ANGELES	Region 16												
90042	LOS ANGELES	Region 16												
90043	LOS ANGELES	Region 16												
90044	LOS ANGELES	Region 16												
90045	LOS ANGELES	Region 16												
90046	LOS ANGELES	Region 16												
90047	LOS ANGELES	Region 16												
90048	LOS ANGELES	Region 16												
90049	LOS ANGELES	Region 16												
90050	LOS ANGELES	Region 16												
90051	LOS ANGELES	Region 16												
90052	LOS ANGELES	Region 16												
90053	LOS ANGELES	Region 16												
90054	LOS ANGELES	Region 16												
90055	LOS ANGELES	Region 16												
90056	LOS ANGELES	Region 16												
90057	LOS ANGELES	Region 16												
90058	LOS ANGELES	Region 16												
90059	LOS ANGELES	Region 16												
90060	LOS ANGELES	Region 16												
90061	LOS ANGELES	Region 16												
90062	LOS ANGELES	Region 16												
90063	LOS ANGELES	Region 16												
90064	LOS ANGELES	Region 16												
90065	LOS ANGELES	Region 16												
90066	LOS ANGELES	Region 16												
90067	LOS ANGELES	Region 16												
90068	LOS ANGELES	Region 16												
90069	LOS ANGELES	Region 16												
90070	LOS ANGELES	Region 16												
90071	LOS ANGELES	Region 16												
90072	LOS ANGELES	Region 16												
90073	LOS ANGELES	Region 16												
90074	LOS ANGELES	Region 16												
90075	LOS ANGELES	Region 16												
90076	LOS ANGELES	Region 16												
90077	LOS ANGELES	Region 16												
90078	LOS ANGELES	Region 16												
90079	LOS ANGELES	Region 16												
90080	LOS ANGELES	Region 16												
90081	LOS ANGELES	Region 16												
90082	LOS ANGELES	Region 16												
90083	LOS ANGELES	Region 16												
90084	LOS ANGELES	Region 16												
90086	LOS ANGELES	Region 16												
90087	LOS ANGELES	Region 16												
90088	LOS ANGELES	Region 16												
90089	LOS ANGELES	Region 16												
90091	LOS ANGELES	Region 16												
90093	LOS ANGELES	Region 16												
90094	LOS ANGELES	Region 16												
90095	LOS ANGELES	Region 16												
90096	LOS ANGELES	Region 16												
90099	LOS ANGELES	Region 16												
90101	LOS ANGELES	Region 16												
90102	LOS ANGELES	Region 16												
90103	LOS ANGELES	Region 16												
90189	LOS ANGELES	Region 16												
90201	LOS ANGELES	Region 16												
90202	LOS ANGELES	Region 16												
90209	LOS ANGELES	Region 16												
90210	LOS ANGELES	Region 16												
90211	LOS ANGELES	Region 16												
90212	LOS ANGELES	Region 16												
90213	LOS ANGELES	Region 16												
90220	LOS ANGELES	Region 16												
90221	LOS ANGELES	Region 16												
90222	LOS ANGELES	Region 16												
90223	LOS ANGELES	Region 16												
90224	LOS ANGELES	Region 16												
90230	LOS ANGELES	Region 16												
90231	LOS ANGELES	Region 16												
90232	LOS ANGELES	Region 16												
90233	LOS ANGELES	Region 16												
90239	LOS ANGELES	Region 16												
90240	LOS ANGELES	Region 16												
90241	LOS ANGELES	Region 16												
90242	LOS ANGELES	Region 16												
90245	LOS ANGELES	Region 16												
90247	LOS ANGELES	Region 16												
90248	LOS ANGELES	Region 16												
90249	LOS ANGELES	Region 16												
90250	LOS ANGELES	Region 16												
90251	LOS ANGELES	Region 16												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
90254	LOS ANGELES	Region 16												
90255	LOS ANGELES	Region 16												
90260	LOS ANGELES	Region 16												
90261	LOS ANGELES	Region 16												
90262	LOS ANGELES	Region 16												
90263	LOS ANGELES	Region 16												
90264	LOS ANGELES	Region 16												
90265	LOS ANGELES	Region 16												
90266	LOS ANGELES	Region 16												
90267	LOS ANGELES	Region 16												
90270	LOS ANGELES	Region 16												
90272	LOS ANGELES	Region 16												
90274	LOS ANGELES	Region 16												
90275	LOS ANGELES	Region 16												
90277	LOS ANGELES	Region 16												
90278	LOS ANGELES	Region 16												
90280	LOS ANGELES	Region 16												
90290	LOS ANGELES	Region 16												
90291	LOS ANGELES	Region 16												
90292	LOS ANGELES	Region 16												
90293	LOS ANGELES	Region 16												
90294	LOS ANGELES	Region 16												
90295	LOS ANGELES	Region 16												
90296	LOS ANGELES	Region 16												
90301	LOS ANGELES	Region 16												
90302	LOS ANGELES	Region 16												
90303	LOS ANGELES	Region 16												
90304	LOS ANGELES	Region 16												
90305	LOS ANGELES	Region 16												
90306	LOS ANGELES	Region 16												
90307	LOS ANGELES	Region 16												
90308	LOS ANGELES	Region 16												
90309	LOS ANGELES	Region 16												
90310	LOS ANGELES	Region 16												
90311	LOS ANGELES	Region 16												
90312	LOS ANGELES	Region 16												
90313	LOS ANGELES	Region 16												
90397	LOS ANGELES	Region 16												
90398	LOS ANGELES	Region 16												
90401	LOS ANGELES	Region 16												
90402	LOS ANGELES	Region 16												
90403	LOS ANGELES	Region 16												
90404	LOS ANGELES	Region 16												
90405	LOS ANGELES	Region 16												
90406	LOS ANGELES	Region 16												
90407	LOS ANGELES	Region 16												
90408	LOS ANGELES	Region 16												
90409	LOS ANGELES	Region 16												
90410	LOS ANGELES	Region 16												
90411	LOS ANGELES	Region 16												
90501	LOS ANGELES	Region 16												
90502	LOS ANGELES	Region 16												
90503	LOS ANGELES	Region 16												
90504	LOS ANGELES	Region 16												
90505	LOS ANGELES	Region 16												
90506	LOS ANGELES	Region 16												
90507	LOS ANGELES	Region 16												
90508	LOS ANGELES	Region 16												
90509	LOS ANGELES	Region 16												
90510	LOS ANGELES	Region 16												
90601	LOS ANGELES	Region 15												
90602	LOS ANGELES	Region 15												
90603	LOS ANGELES	Region 15												
90604	LOS ANGELES	Region 15												
90605	LOS ANGELES	Region 15												
90606	LOS ANGELES	Region 15												
90607	LOS ANGELES	Region 15												
90608	LOS ANGELES	Region 15												
90609	LOS ANGELES	Region 15												
90610	LOS ANGELES	Region 15												
90612	LOS ANGELES	Region 15												
90637	LOS ANGELES	Region 15												
90638	LOS ANGELES	Region 15												
90639	LOS ANGELES	Region 15												
90640	LOS ANGELES	Region 15												
90650	LOS ANGELES	Region 15												
90651	LOS ANGELES	Region 15												
90652	LOS ANGELES	Region 15												
90659	LOS ANGELES	Region 15												
90660	LOS ANGELES	Region 15												
90661	LOS ANGELES	Region 15												
90662	LOS ANGELES	Region 15												
90670	LOS ANGELES	Region 15												
90671	LOS ANGELES	Region 15												
90701	LOS ANGELES	Region 15												
90702	LOS ANGELES	Region 15												
90703	LOS ANGELES	Region 15												
90704	LOS ANGELES	Region 15												
90706	LOS ANGELES	Region 15												
90707	LOS ANGELES	Region 15												
90710	LOS ANGELES	Region 15												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
90711	LOS ANGELES	Region 15												
90712	LOS ANGELES	Region 15												
90713	LOS ANGELES	Region 15												
90714	LOS ANGELES	Region 15												
90715	LOS ANGELES	Region 15												
90716	LOS ANGELES	Region 15												
90717	LOS ANGELES	Region 15												
90723	LOS ANGELES	Region 15												
90731	LOS ANGELES	Region 15												
90732	LOS ANGELES	Region 15												
90733	LOS ANGELES	Region 15												
90734	LOS ANGELES	Region 15												
90744	LOS ANGELES	Region 15												
90745	LOS ANGELES	Region 15												
90746	LOS ANGELES	Region 15												
90747	LOS ANGELES	Region 15												
90748	LOS ANGELES	Region 15												
90749	LOS ANGELES	Region 15												
90755	LOS ANGELES	Region 15												
90801	LOS ANGELES	Region 15												
90802	LOS ANGELES	Region 15												
90803	LOS ANGELES	Region 15												
90804	LOS ANGELES	Region 15												
90805	LOS ANGELES	Region 15												
90806	LOS ANGELES	Region 15												
90807	LOS ANGELES	Region 15												
90808	LOS ANGELES	Region 15												
90809	LOS ANGELES	Region 15												
90810	LOS ANGELES	Region 15												
90813	LOS ANGELES	Region 15												
90814	LOS ANGELES	Region 15												
90815	LOS ANGELES	Region 15												
90822	LOS ANGELES	Region 15												
90831	LOS ANGELES	Region 15												
90832	LOS ANGELES	Region 15												
90833	LOS ANGELES	Region 15												
90834	LOS ANGELES	Region 15												
90835	LOS ANGELES	Region 15												
90840	LOS ANGELES	Region 15												
90842	LOS ANGELES	Region 15												
90844	LOS ANGELES	Region 15												
90845	LOS ANGELES	Region 15												
90846	LOS ANGELES	Region 15												
90847	LOS ANGELES	Region 15												
90848	LOS ANGELES	Region 15												
90853	LOS ANGELES	Region 15												
90888	LOS ANGELES	Region 15												
90895	LOS ANGELES	Region 15												
90899	LOS ANGELES	Region 15												
91001	LOS ANGELES	Region 15												
91003	LOS ANGELES	Region 15												
91006	LOS ANGELES	Region 15												
91007	LOS ANGELES	Region 15												
91008	LOS ANGELES	Region 15												
91009	LOS ANGELES	Region 15												
91010	LOS ANGELES	Region 15												
91011	LOS ANGELES	Region 15												
91012	LOS ANGELES	Region 15												
91016	LOS ANGELES	Region 15												
91017	LOS ANGELES	Region 15												
91020	LOS ANGELES	Region 15												
91021	LOS ANGELES	Region 15												
91023	LOS ANGELES	Region 15												
91024	LOS ANGELES	Region 15												
91025	LOS ANGELES	Region 15												
91030	LOS ANGELES	Region 15												
91031	LOS ANGELES	Region 15												
91040	LOS ANGELES	Region 15												
91041	LOS ANGELES	Region 15												
91042	LOS ANGELES	Region 15												
91043	LOS ANGELES	Region 15												
91046	LOS ANGELES	Region 15												
91066	LOS ANGELES	Region 15												
91077	LOS ANGELES	Region 15												
91101	LOS ANGELES	Region 15												
91102	LOS ANGELES	Region 15												
91103	LOS ANGELES	Region 15												
91104	LOS ANGELES	Region 15												
91105	LOS ANGELES	Region 15												
91106	LOS ANGELES	Region 15												
91107	LOS ANGELES	Region 15												
91108	LOS ANGELES	Region 15												
91109	LOS ANGELES	Region 15												
91110	LOS ANGELES	Region 15												
91114	LOS ANGELES	Region 15												
91115	LOS ANGELES	Region 15												
91116	LOS ANGELES	Region 15												
91117	LOS ANGELES	Region 15												
91118	LOS ANGELES	Region 15												
91121	LOS ANGELES	Region 15												
91123	LOS ANGELES	Region 15												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
91124	LOS ANGELES	Region 15												
91125	LOS ANGELES	Region 15												
91126	LOS ANGELES	Region 15												
91129	LOS ANGELES	Region 15												
91131	LOS ANGELES	Region 15												
91182	LOS ANGELES	Region 15												
91184	LOS ANGELES	Region 15												
91185	LOS ANGELES	Region 15												
91188	LOS ANGELES	Region 15												
91189	LOS ANGELES	Region 15												
91191	LOS ANGELES	Region 15												
91199	LOS ANGELES	Region 15												
91201	LOS ANGELES	Region 15												
91202	LOS ANGELES	Region 15												
91203	LOS ANGELES	Region 15												
91204	LOS ANGELES	Region 15												
91205	LOS ANGELES	Region 15												
91206	LOS ANGELES	Region 15												
91207	LOS ANGELES	Region 15												
91208	LOS ANGELES	Region 15												
91209	LOS ANGELES	Region 15												
91210	LOS ANGELES	Region 15												
91214	LOS ANGELES	Region 15												
91221	LOS ANGELES	Region 15												
91222	LOS ANGELES	Region 15												
91224	LOS ANGELES	Region 15												
91225	LOS ANGELES	Region 15												
91226	LOS ANGELES	Region 15												
91301	LOS ANGELES	Region 16												
91302	LOS ANGELES	Region 16												
91303	LOS ANGELES	Region 16												
91304	LOS ANGELES	Region 16												
91305	LOS ANGELES	Region 16												
91306	LOS ANGELES	Region 16												
91307	LOS ANGELES	Region 16												
91308	LOS ANGELES	Region 16												
91309	LOS ANGELES	Region 16												
91310	LOS ANGELES	Region 16												
91311	LOS ANGELES	Region 16												
91313	LOS ANGELES	Region 16												
91316	LOS ANGELES	Region 16												
91321	LOS ANGELES	Region 16												
91322	LOS ANGELES	Region 16												
91324	LOS ANGELES	Region 16												
91325	LOS ANGELES	Region 16												
91326	LOS ANGELES	Region 16												
91327	LOS ANGELES	Region 16												
91328	LOS ANGELES	Region 16												
91329	LOS ANGELES	Region 16												
91330	LOS ANGELES	Region 16												
91331	LOS ANGELES	Region 16												
91333	LOS ANGELES	Region 16												
91334	LOS ANGELES	Region 16												
91335	LOS ANGELES	Region 16												
91337	LOS ANGELES	Region 16												
91340	LOS ANGELES	Region 16												
91341	LOS ANGELES	Region 16												
91342	LOS ANGELES	Region 16												
91343	LOS ANGELES	Region 16												
91344	LOS ANGELES	Region 16												
91345	LOS ANGELES	Region 16												
91346	LOS ANGELES	Region 16												
91350	LOS ANGELES	Region 16												
91351	LOS ANGELES	Region 16												
91352	LOS ANGELES	Region 16												
91353	LOS ANGELES	Region 16												
91354	LOS ANGELES	Region 16												
91355	LOS ANGELES	Region 16												
91356	LOS ANGELES	Region 16												
91357	LOS ANGELES	Region 16												
91363	LOS ANGELES	Region 16												
91364	LOS ANGELES	Region 16												
91365	LOS ANGELES	Region 16												
91367	LOS ANGELES	Region 16												
91371	LOS ANGELES	Region 16												
91372	LOS ANGELES	Region 16												
91376	LOS ANGELES	Region 16												
91380	LOS ANGELES	Region 16												
91381	LOS ANGELES	Region 16												
91382	LOS ANGELES	Region 16												
91383	LOS ANGELES	Region 16												
91384	LOS ANGELES	Region 16												
91385	LOS ANGELES	Region 16												
91386	LOS ANGELES	Region 16												
91387	LOS ANGELES	Region 16												
91390	LOS ANGELES	Region 16												
91392	LOS ANGELES	Region 16												
91393	LOS ANGELES	Region 16												
91394	LOS ANGELES	Region 16												
91395	LOS ANGELES	Region 16												
91396	LOS ANGELES	Region 16												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
91399	LOS ANGELES	Region 16												
91401	LOS ANGELES	Region 16												
91402	LOS ANGELES	Region 16												
91403	LOS ANGELES	Region 16												
91404	LOS ANGELES	Region 16												
91405	LOS ANGELES	Region 16												
91406	LOS ANGELES	Region 16												
91407	LOS ANGELES	Region 16												
91408	LOS ANGELES	Region 16												
91409	LOS ANGELES	Region 16												
91410	LOS ANGELES	Region 16												
91411	LOS ANGELES	Region 16												
91412	LOS ANGELES	Region 16												
91413	LOS ANGELES	Region 16												
91416	LOS ANGELES	Region 16												
91423	LOS ANGELES	Region 16												
91426	LOS ANGELES	Region 16												
91436	LOS ANGELES	Region 16												
91470	LOS ANGELES	Region 16												
91482	LOS ANGELES	Region 16												
91495	LOS ANGELES	Region 16												
91496	LOS ANGELES	Region 16												
91497	LOS ANGELES	Region 16												
91499	LOS ANGELES	Region 16												
91501	LOS ANGELES	Region 15												
91502	LOS ANGELES	Region 15												
91503	LOS ANGELES	Region 15												
91504	LOS ANGELES	Region 15												
91505	LOS ANGELES	Region 15												
91506	LOS ANGELES	Region 15												
91507	LOS ANGELES	Region 15												
91508	LOS ANGELES	Region 15												
91510	LOS ANGELES	Region 15												
91521	LOS ANGELES	Region 15												
91522	LOS ANGELES	Region 15												
91523	LOS ANGELES	Region 15												
91526	LOS ANGELES	Region 15												
91601	LOS ANGELES	Region 16												
91602	LOS ANGELES	Region 16												
91603	LOS ANGELES	Region 16												
91604	LOS ANGELES	Region 16												
91605	LOS ANGELES	Region 16												
91606	LOS ANGELES	Region 16												
91607	LOS ANGELES	Region 16												
91608	LOS ANGELES	Region 16												
91609	LOS ANGELES	Region 16												
91610	LOS ANGELES	Region 16												
91611	LOS ANGELES	Region 16												
91612	LOS ANGELES	Region 16												
91614	LOS ANGELES	Region 16												
91615	LOS ANGELES	Region 16												
91616	LOS ANGELES	Region 16												
91617	LOS ANGELES	Region 16												
91618	LOS ANGELES	Region 16												
91702	LOS ANGELES	Region 15												
91706	LOS ANGELES	Region 15												
91711	LOS ANGELES	Region 15												
91714	LOS ANGELES	Region 15												
91715	LOS ANGELES	Region 15												
91716	LOS ANGELES	Region 15												
91722	LOS ANGELES	Region 15												
91723	LOS ANGELES	Region 15												
91724	LOS ANGELES	Region 15												
91731	LOS ANGELES	Region 15												
91732	LOS ANGELES	Region 15												
91733	LOS ANGELES	Region 15												
91734	LOS ANGELES	Region 15												
91735	LOS ANGELES	Region 15												
91740	LOS ANGELES	Region 15												
91741	LOS ANGELES	Region 15												
91744	LOS ANGELES	Region 15												
91745	LOS ANGELES	Region 15												
91746	LOS ANGELES	Region 15												
91747	LOS ANGELES	Region 15												
91748	LOS ANGELES	Region 15												
91749	LOS ANGELES	Region 15												
91750	LOS ANGELES	Region 15												
91754	LOS ANGELES	Region 15												
91755	LOS ANGELES	Region 15												
91756	LOS ANGELES	Region 15												
91759	LOS ANGELES	Region 15												
91765	LOS ANGELES	Region 15												
91766	LOS ANGELES	Region 15												
91767	LOS ANGELES	Region 15												
91768	LOS ANGELES	Region 15												
91769	LOS ANGELES	Region 15												
91770	LOS ANGELES	Region 15												
91771	LOS ANGELES	Region 15												
91772	LOS ANGELES	Region 15												
91773	LOS ANGELES	Region 15												
91775	LOS ANGELES	Region 15												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
91776	LOS ANGELES	Region 15												
91778	LOS ANGELES	Region 15												
91780	LOS ANGELES	Region 15												
91788	LOS ANGELES	Region 15												
91789	LOS ANGELES	Region 15												
91790	LOS ANGELES	Region 15												
91791	LOS ANGELES	Region 15												
91792	LOS ANGELES	Region 15												
91793	LOS ANGELES	Region 15												
91795	LOS ANGELES	Region 15												
91797	LOS ANGELES	Region 15												
91799	LOS ANGELES	Region 15												
91801	LOS ANGELES	Region 15												
91802	LOS ANGELES	Region 15												
91803	LOS ANGELES	Region 15												
91804	LOS ANGELES	Region 15												
91841	LOS ANGELES	Region 15												
91896	LOS ANGELES	Region 15												
91899	LOS ANGELES	Region 15												
93510	LOS ANGELES	Region 15												
93532	LOS ANGELES	Region 15												
93534	LOS ANGELES	Region 15												
93535	LOS ANGELES	Region 15												
93536	LOS ANGELES	Region 15												
93539	LOS ANGELES	Region 15												
93543	LOS ANGELES	Region 15												
93544	LOS ANGELES	Region 15												
93550	LOS ANGELES	Region 15												
93551	LOS ANGELES	Region 15												
93552	LOS ANGELES	Region 15												
93553	LOS ANGELES	Region 15												
93563	LOS ANGELES	Region 15												
93584	LOS ANGELES	Region 15												
93586	LOS ANGELES	Region 15												
93590	LOS ANGELES	Region 15												
93591	LOS ANGELES	Region 15												
93599	LOS ANGELES	Region 15												
93601	MADERA	Region 11												
93604	MADERA	Region 11												
93610	MADERA	Region 11												
93614	MADERA	Region 11												
93636	MADERA	Region 11												
93637	MADERA	Region 11												
93638	MADERA	Region 11												
93639	MADERA	Region 11												
93643	MADERA	Region 11												
93644	MADERA	Region 11												
93645	MADERA	Region 11												
93653	MADERA	Region 11												
93669	MADERA	Region 11												
94901	MARIN	Region 2												
94903	MARIN	Region 2												
94904	MARIN	Region 2												
94912	MARIN	Region 2												
94913	MARIN	Region 2												
94914	MARIN	Region 2												
94915	MARIN	Region 2												
94920	MARIN	Region 2												
94924	MARIN	Region 2												
94925	MARIN	Region 2												
94929	MARIN	Region 2												
94930	MARIN	Region 2												
94933	MARIN	Region 2												
94937	MARIN	Region 2												
94938	MARIN	Region 2												
94939	MARIN	Region 2												
94940	MARIN	Region 2												
94941	MARIN	Region 2												
94942	MARIN	Region 2												
94945	MARIN	Region 2												
94946	MARIN	Region 2												
94947	MARIN	Region 2												
94948	MARIN	Region 2												
94949	MARIN	Region 2												
94950	MARIN	Region 2												
94956	MARIN	Region 2												
94957	MARIN	Region 2												
94960	MARIN	Region 2												
94963	MARIN	Region 2												
94964	MARIN	Region 2												
94965	MARIN	Region 2												
94966	MARIN	Region 2												
94970	MARIN	Region 2												
94971	MARIN	Region 2												
94973	MARIN	Region 2												
94974	MARIN	Region 2												
94976	MARIN	Region 2												
94977	MARIN	Region 2												
94978	MARIN	Region 2												
94979	MARIN	Region 2												
94998	MARIN	Region 2												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93623	MARIPOSA	Region 10												
95306	MARIPOSA	Region 10												
95311	MARIPOSA	Region 10												
95318	MARIPOSA	Region 10												
95325	MARIPOSA	Region 10												
95338	MARIPOSA	Region 10												
95345	MARIPOSA	Region 10												
95389	MARIPOSA	Region 10												
95410	MENDOCINO	Region 1												
95415	MENDOCINO	Region 1												
95417	MENDOCINO	Region 1												
95418	MENDOCINO	Region 1												
95420	MENDOCINO	Region 1												
95427	MENDOCINO	Region 1												
95428	MENDOCINO	Region 1												
95429	MENDOCINO	Region 1												
95432	MENDOCINO	Region 1												
95437	MENDOCINO	Region 1												
95445	MENDOCINO	Region 1												
95449	MENDOCINO	Region 1												
95454	MENDOCINO	Region 1												
95456	MENDOCINO	Region 1												
95459	MENDOCINO	Region 1												
95460	MENDOCINO	Region 1												
95463	MENDOCINO	Region 1												
95466	MENDOCINO	Region 1												
95468	MENDOCINO	Region 1												
95469	MENDOCINO	Region 1												
95470	MENDOCINO	Region 1												
95481	MENDOCINO	Region 1												
95482	MENDOCINO	Region 1												
95488	MENDOCINO	Region 1												
95490	MENDOCINO	Region 1												
95494	MENDOCINO	Region 1												
95585	MENDOCINO	Region 1												
95587	MENDOCINO	Region 1												
93620	MERCED	Region 10												
93635	MERCED	Region 10												
93661	MERCED	Region 10												
93665	MERCED	Region 10												
95301	MERCED	Region 10												
95303	MERCED	Region 10												
95312	MERCED	Region 10												
95315	MERCED	Region 10												
95317	MERCED	Region 10												
95322	MERCED	Region 10												
95324	MERCED	Region 10												
95333	MERCED	Region 10												
95334	MERCED	Region 10												
95340	MERCED	Region 10												
95341	MERCED	Region 10												
95343	MERCED	Region 10												
95344	MERCED	Region 10												
95348	MERCED	Region 10												
95365	MERCED	Region 10												
95369	MERCED	Region 10												
95374	MERCED	Region 10												
95388	MERCED	Region 10												
96006	MODOC	Region 1												
96015	MODOC	Region 1												
96054	MODOC	Region 1												
96101	MODOC	Region 1												
96104	MODOC	Region 1												
96108	MODOC	Region 1												
96110	MODOC	Region 1												
96112	MODOC	Region 1												
96115	MODOC	Region 1												
96116	MODOC	Region 1												
93512	MONO	Region 13												
93517	MONO	Region 13												
93529	MONO	Region 13												
93541	MONO	Region 13												
93546	MONO	Region 13												
96107	MONO	Region 13												
96133	MONO	Region 13												
93426	MONTEREY	Region 9												
93450	MONTEREY	Region 9												
93901	MONTEREY	Region 9												
93902	MONTEREY	Region 9												
93905	MONTEREY	Region 9												
93906	MONTEREY	Region 9												
93907	MONTEREY	Region 9												
93908	MONTEREY	Region 9												
93912	MONTEREY	Region 9												
93915	MONTEREY	Region 9												
93920	MONTEREY	Region 9												
93921	MONTEREY	Region 9												
93922	MONTEREY	Region 9												
93923	MONTEREY	Region 9												
93924	MONTEREY	Region 9												
93925	MONTEREY	Region 9												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93926	MONTEREY	Region 9												
93927	MONTEREY	Region 9												
93928	MONTEREY	Region 9												
93930	MONTEREY	Region 9												
93932	MONTEREY	Region 9												
93933	MONTEREY	Region 9												
93940	MONTEREY	Region 9												
93942	MONTEREY	Region 9												
93943	MONTEREY	Region 9												
93944	MONTEREY	Region 9												
93950	MONTEREY	Region 9												
93953	MONTEREY	Region 9												
93954	MONTEREY	Region 9												
93955	MONTEREY	Region 9												
93960	MONTEREY	Region 9												
93962	MONTEREY	Region 9												
95004	MONTEREY	Region 9												
95012	MONTEREY	Region 9												
95039	MONTEREY	Region 9												
94503	NAPA	Region 2												
94508	NAPA	Region 2												
94515	NAPA	Region 2												
94558	NAPA	Region 2												
94559	NAPA	Region 2												
94562	NAPA	Region 2												
94567	NAPA	Region 2												
94573	NAPA	Region 2												
94574	NAPA	Region 2												
94576	NAPA	Region 2												
94581	NAPA	Region 2												
94599	NAPA	Region 2												
95712	NEVADA	Region 1												
95724	NEVADA	Region 1												
95728	NEVADA	Region 1												
95924	NEVADA	Region 1												
95945	NEVADA	Region 1												
95946	NEVADA	Region 1												
95949	NEVADA	Region 1												
95959	NEVADA	Region 1												
95960	NEVADA	Region 1												
95975	NEVADA	Region 1												
95977	NEVADA	Region 1												
95986	NEVADA	Region 1												
96111	NEVADA	Region 1												
96160	NEVADA	Region 1												
96161	NEVADA	Region 1												
96162	NEVADA	Region 1												
90620	ORANGE	Region 18												
90621	ORANGE	Region 18												
90622	ORANGE	Region 18												
90623	ORANGE	Region 18												
90624	ORANGE	Region 18												
90630	ORANGE	Region 18												
90631	ORANGE	Region 18												
90632	ORANGE	Region 18												
90633	ORANGE	Region 18												
90680	ORANGE	Region 18												
90720	ORANGE	Region 18												
90721	ORANGE	Region 18												
90740	ORANGE	Region 18												
90742	ORANGE	Region 18												
90743	ORANGE	Region 18												
92602	ORANGE	Region 18												
92603	ORANGE	Region 18												
92604	ORANGE	Region 18												
92605	ORANGE	Region 18												
92606	ORANGE	Region 18												
92607	ORANGE	Region 18												
92609	ORANGE	Region 18												
92610	ORANGE	Region 18												
92612	ORANGE	Region 18												
92614	ORANGE	Region 18												
92615	ORANGE	Region 18												
92616	ORANGE	Region 18												
92617	ORANGE	Region 18												
92618	ORANGE	Region 18												
92619	ORANGE	Region 18												
92620	ORANGE	Region 18												
92623	ORANGE	Region 18												
92624	ORANGE	Region 18												
92625	ORANGE	Region 18												
92626	ORANGE	Region 18												
92627	ORANGE	Region 18												
92628	ORANGE	Region 18												
92629	ORANGE	Region 18												
92630	ORANGE	Region 18												
92637	ORANGE	Region 18												
92646	ORANGE	Region 18												
92647	ORANGE	Region 18												
92648	ORANGE	Region 18												
92649	ORANGE	Region 18												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
92650	ORANGE	Region 18												
92651	ORANGE	Region 18												
92652	ORANGE	Region 18												
92653	ORANGE	Region 18												
92654	ORANGE	Region 18												
92655	ORANGE	Region 18												
92656	ORANGE	Region 18												
92657	ORANGE	Region 18												
92658	ORANGE	Region 18												
92659	ORANGE	Region 18												
92660	ORANGE	Region 18												
92661	ORANGE	Region 18												
92662	ORANGE	Region 18												
92663	ORANGE	Region 18												
92672	ORANGE	Region 18												
92673	ORANGE	Region 18												
92674	ORANGE	Region 18												
92675	ORANGE	Region 18												
92676	ORANGE	Region 18												
92677	ORANGE	Region 18												
92678	ORANGE	Region 18												
92679	ORANGE	Region 18												
92683	ORANGE	Region 18												
92684	ORANGE	Region 18												
92685	ORANGE	Region 18												
92688	ORANGE	Region 18												
92690	ORANGE	Region 18												
92691	ORANGE	Region 18												
92692	ORANGE	Region 18												
92693	ORANGE	Region 18												
92694	ORANGE	Region 18												
92697	ORANGE	Region 18												
92698	ORANGE	Region 18												
92701	ORANGE	Region 18												
92702	ORANGE	Region 18												
92703	ORANGE	Region 18												
92704	ORANGE	Region 18												
92705	ORANGE	Region 18												
92706	ORANGE	Region 18												
92707	ORANGE	Region 18												
92708	ORANGE	Region 18												
92709	ORANGE	Region 18												
92710	ORANGE	Region 18												
92711	ORANGE	Region 18												
92712	ORANGE	Region 18												
92725	ORANGE	Region 18												
92728	ORANGE	Region 18												
92735	ORANGE	Region 18												
92780	ORANGE	Region 18												
92781	ORANGE	Region 18												
92782	ORANGE	Region 18												
92799	ORANGE	Region 18												
92801	ORANGE	Region 18												
92802	ORANGE	Region 18												
92803	ORANGE	Region 18												
92804	ORANGE	Region 18												
92805	ORANGE	Region 18												
92806	ORANGE	Region 18												
92807	ORANGE	Region 18												
92808	ORANGE	Region 18												
92809	ORANGE	Region 18												
92811	ORANGE	Region 18												
92812	ORANGE	Region 18												
92814	ORANGE	Region 18												
92815	ORANGE	Region 18												
92816	ORANGE	Region 18												
92817	ORANGE	Region 18												
92821	ORANGE	Region 18												
92822	ORANGE	Region 18												
92823	ORANGE	Region 18												
92825	ORANGE	Region 18												
92831	ORANGE	Region 18												
92832	ORANGE	Region 18												
92833	ORANGE	Region 18												
92834	ORANGE	Region 18												
92835	ORANGE	Region 18												
92836	ORANGE	Region 18												
92837	ORANGE	Region 18												
92838	ORANGE	Region 18												
92840	ORANGE	Region 18												
92841	ORANGE	Region 18												
92842	ORANGE	Region 18												
92843	ORANGE	Region 18												
92844	ORANGE	Region 18												
92845	ORANGE	Region 18												
92846	ORANGE	Region 18												
92850	ORANGE	Region 18												
92856	ORANGE	Region 18												
92857	ORANGE	Region 18												
92859	ORANGE	Region 18												
92861	ORANGE	Region 18												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
92862	ORANGE	Region 18												
92863	ORANGE	Region 18												
92864	ORANGE	Region 18												
92865	ORANGE	Region 18												
92866	ORANGE	Region 18												
92867	ORANGE	Region 18												
92868	ORANGE	Region 18												
92869	ORANGE	Region 18												
92870	ORANGE	Region 18												
92871	ORANGE	Region 18												
92885	ORANGE	Region 18												
92886	ORANGE	Region 18												
92887	ORANGE	Region 18												
92899	ORANGE	Region 18												
95602	PLACER	Region 3												
95603	PLACER	Region 3												
95604	PLACER	Region 3												
95631	PLACER	Region 3												
95648	PLACER	Region 3												
95650	PLACER	Region 3												
95658	PLACER	Region 3												
95661	PLACER	Region 3												
95663	PLACER	Region 3												
95677	PLACER	Region 3												
95678	PLACER	Region 3												
95681	PLACER	Region 3												
95701	PLACER	Region 3												
95703	PLACER	Region 3												
95713	PLACER	Region 3												
95714	PLACER	Region 3												
95715	PLACER	Region 3												
95717	PLACER	Region 3												
95722	PLACER	Region 3												
95736	PLACER	Region 3												
95746	PLACER	Region 3												
95747	PLACER	Region 3												
95765	PLACER	Region 3												
96140	PLACER	Region 3												
96141	PLACER	Region 3												
96143	PLACER	Region 3												
96145	PLACER	Region 3												
96146	PLACER	Region 3												
96148	PLACER	Region 3												
95915	PLUMAS	Region 1												
95923	PLUMAS	Region 1												
95934	PLUMAS	Region 1												
95947	PLUMAS	Region 1												
95956	PLUMAS	Region 1												
95971	PLUMAS	Region 1												
95980	PLUMAS	Region 1												
95983	PLUMAS	Region 1												
95984	PLUMAS	Region 1												
96020	PLUMAS	Region 1												
96103	PLUMAS	Region 1												
96105	PLUMAS	Region 1												
96106	PLUMAS	Region 1												
96122	PLUMAS	Region 1												
96129	PLUMAS	Region 1												
96135	PLUMAS	Region 1												
91720	RIVERSIDE	Region 17												
91752	RIVERSIDE	Region 17												
92201	RIVERSIDE	Region 17												
92202	RIVERSIDE	Region 17												
92203	RIVERSIDE	Region 17												
92210	RIVERSIDE	Region 17												
92211	RIVERSIDE	Region 17												
92220	RIVERSIDE	Region 17												
92223	RIVERSIDE	Region 17												
92225	RIVERSIDE	Region 17												
92226	RIVERSIDE	Region 17												
92230	RIVERSIDE	Region 17												
92234	RIVERSIDE	Region 17												
92235	RIVERSIDE	Region 17												
92236	RIVERSIDE	Region 17												
92239	RIVERSIDE	Region 17												
92240	RIVERSIDE	Region 17												
92241	RIVERSIDE	Region 17												
92247	RIVERSIDE	Region 17												
92248	RIVERSIDE	Region 17												
92253	RIVERSIDE	Region 17												
92254	RIVERSIDE	Region 17												
92255	RIVERSIDE	Region 17												
92258	RIVERSIDE	Region 17												
92260	RIVERSIDE	Region 17												
92261	RIVERSIDE	Region 17												
92262	RIVERSIDE	Region 17												
92263	RIVERSIDE	Region 17												
92264	RIVERSIDE	Region 17												
92270	RIVERSIDE	Region 17												
92274	RIVERSIDE	Region 17												
92276	RIVERSIDE	Region 17												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
92282	RIVERSIDE	Region 17												
92292	RIVERSIDE	Region 17												
92320	RIVERSIDE	Region 17												
92330	RIVERSIDE	Region 17												
92343	RIVERSIDE	Region 17												
92501	RIVERSIDE	Region 17												
92502	RIVERSIDE	Region 17												
92503	RIVERSIDE	Region 17												
92504	RIVERSIDE	Region 17												
92505	RIVERSIDE	Region 17												
92506	RIVERSIDE	Region 17												
92507	RIVERSIDE	Region 17												
92508	RIVERSIDE	Region 17												
92509	RIVERSIDE	Region 17												
92513	RIVERSIDE	Region 17												
92514	RIVERSIDE	Region 17												
92515	RIVERSIDE	Region 17												
92516	RIVERSIDE	Region 17												
92517	RIVERSIDE	Region 17												
92518	RIVERSIDE	Region 17												
92519	RIVERSIDE	Region 17												
92521	RIVERSIDE	Region 17												
92522	RIVERSIDE	Region 17												
92530	RIVERSIDE	Region 17												
92531	RIVERSIDE	Region 17												
92532	RIVERSIDE	Region 17												
92536	RIVERSIDE	Region 17												
92539	RIVERSIDE	Region 17												
92543	RIVERSIDE	Region 17												
92544	RIVERSIDE	Region 17												
92545	RIVERSIDE	Region 17												
92546	RIVERSIDE	Region 17												
92548	RIVERSIDE	Region 17												
92549	RIVERSIDE	Region 17												
92551	RIVERSIDE	Region 17												
92552	RIVERSIDE	Region 17												
92553	RIVERSIDE	Region 17												
92554	RIVERSIDE	Region 17												
92555	RIVERSIDE	Region 17												
92556	RIVERSIDE	Region 17												
92557	RIVERSIDE	Region 17												
92561	RIVERSIDE	Region 17												
92562	RIVERSIDE	Region 17												
92563	RIVERSIDE	Region 17												
92564	RIVERSIDE	Region 17												
92567	RIVERSIDE	Region 17												
92570	RIVERSIDE	Region 17												
92571	RIVERSIDE	Region 17												
92572	RIVERSIDE	Region 17												
92581	RIVERSIDE	Region 17												
92582	RIVERSIDE	Region 17												
92583	RIVERSIDE	Region 17												
92584	RIVERSIDE	Region 17												
92585	RIVERSIDE	Region 17												
92586	RIVERSIDE	Region 17												
92587	RIVERSIDE	Region 17												
92589	RIVERSIDE	Region 17												
92590	RIVERSIDE	Region 17												
92591	RIVERSIDE	Region 17												
92592	RIVERSIDE	Region 17												
92593	RIVERSIDE	Region 17												
92595	RIVERSIDE	Region 17												
92596	RIVERSIDE	Region 17												
92599	RIVERSIDE	Region 17												
92860	RIVERSIDE	Region 17												
92877	RIVERSIDE	Region 17												
92878	RIVERSIDE	Region 17												
92879	RIVERSIDE	Region 17												
92880	RIVERSIDE	Region 17												
92881	RIVERSIDE	Region 17												
92882	RIVERSIDE	Region 17												
92883	RIVERSIDE	Region 17												
94203	SACRAMENTO	Region 3												
94204	SACRAMENTO	Region 3												
94205	SACRAMENTO	Region 3												
94206	SACRAMENTO	Region 3												
94207	SACRAMENTO	Region 3												
94208	SACRAMENTO	Region 3												
94209	SACRAMENTO	Region 3												
94211	SACRAMENTO	Region 3												
94229	SACRAMENTO	Region 3												
94230	SACRAMENTO	Region 3												
94232	SACRAMENTO	Region 3												
94234	SACRAMENTO	Region 3												
94235	SACRAMENTO	Region 3												
94236	SACRAMENTO	Region 3												
94237	SACRAMENTO	Region 3												
94239	SACRAMENTO	Region 3												
94240	SACRAMENTO	Region 3												
94244	SACRAMENTO	Region 3												
94245	SACRAMENTO	Region 3												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
94246	SACRAMENTO	Region 3												
94247	SACRAMENTO	Region 3												
94248	SACRAMENTO	Region 3												
94249	SACRAMENTO	Region 3												
94250	SACRAMENTO	Region 3												
94252	SACRAMENTO	Region 3												
94254	SACRAMENTO	Region 3												
94256	SACRAMENTO	Region 3												
94257	SACRAMENTO	Region 3												
94258	SACRAMENTO	Region 3												
94259	SACRAMENTO	Region 3												
94261	SACRAMENTO	Region 3												
94262	SACRAMENTO	Region 3												
94263	SACRAMENTO	Region 3												
94267	SACRAMENTO	Region 3												
94268	SACRAMENTO	Region 3												
94269	SACRAMENTO	Region 3												
94271	SACRAMENTO	Region 3												
94273	SACRAMENTO	Region 3												
94274	SACRAMENTO	Region 3												
94277	SACRAMENTO	Region 3												
94278	SACRAMENTO	Region 3												
94279	SACRAMENTO	Region 3												
94280	SACRAMENTO	Region 3												
94282	SACRAMENTO	Region 3												
94283	SACRAMENTO	Region 3												
94284	SACRAMENTO	Region 3												
94285	SACRAMENTO	Region 3												
94286	SACRAMENTO	Region 3												
94287	SACRAMENTO	Region 3												
94288	SACRAMENTO	Region 3												
94289	SACRAMENTO	Region 3												
94290	SACRAMENTO	Region 3												
94291	SACRAMENTO	Region 3												
94293	SACRAMENTO	Region 3												
94294	SACRAMENTO	Region 3												
94295	SACRAMENTO	Region 3												
94296	SACRAMENTO	Region 3												
94297	SACRAMENTO	Region 3												
94298	SACRAMENTO	Region 3												
94299	SACRAMENTO	Region 3												
95608	SACRAMENTO	Region 3												
95609	SACRAMENTO	Region 3												
95610	SACRAMENTO	Region 3												
95611	SACRAMENTO	Region 3												
95615	SACRAMENTO	Region 3												
95621	SACRAMENTO	Region 3												
95624	SACRAMENTO	Region 3												
95626	SACRAMENTO	Region 3												
95628	SACRAMENTO	Region 3												
95630	SACRAMENTO	Region 3												
95632	SACRAMENTO	Region 3												
95638	SACRAMENTO	Region 3												
95639	SACRAMENTO	Region 3												
95641	SACRAMENTO	Region 3												
95652	SACRAMENTO	Region 3												
95655	SACRAMENTO	Region 3												
95660	SACRAMENTO	Region 3												
95662	SACRAMENTO	Region 3												
95670	SACRAMENTO	Region 3												
95671	SACRAMENTO	Region 3												
95673	SACRAMENTO	Region 3												
95680	SACRAMENTO	Region 3												
95683	SACRAMENTO	Region 3												
95690	SACRAMENTO	Region 3												
95693	SACRAMENTO	Region 3												
95741	SACRAMENTO	Region 3												
95742	SACRAMENTO	Region 3												
95757	SACRAMENTO	Region 3												
95758	SACRAMENTO	Region 3												
95759	SACRAMENTO	Region 3												
95763	SACRAMENTO	Region 3												
95811	SACRAMENTO	Region 3												
95812	SACRAMENTO	Region 3												
95813	SACRAMENTO	Region 3												
95814	SACRAMENTO	Region 3												
95815	SACRAMENTO	Region 3												
95816	SACRAMENTO	Region 3												
95817	SACRAMENTO	Region 3												
95818	SACRAMENTO	Region 3												
95819	SACRAMENTO	Region 3												
95820	SACRAMENTO	Region 3												
95821	SACRAMENTO	Region 3												
95822	SACRAMENTO	Region 3												
95823	SACRAMENTO	Region 3												
95824	SACRAMENTO	Region 3												
95825	SACRAMENTO	Region 3												
95826	SACRAMENTO	Region 3												
95827	SACRAMENTO	Region 3												
95828	SACRAMENTO	Region 3												
95829	SACRAMENTO	Region 3												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95830	SACRAMENTO	Region 3												
95831	SACRAMENTO	Region 3												
95832	SACRAMENTO	Region 3												
95833	SACRAMENTO	Region 3												
95834	SACRAMENTO	Region 3												
95835	SACRAMENTO	Region 3												
95836	SACRAMENTO	Region 3												
95837	SACRAMENTO	Region 3												
95838	SACRAMENTO	Region 3												
95840	SACRAMENTO	Region 3												
95841	SACRAMENTO	Region 3												
95842	SACRAMENTO	Region 3												
95843	SACRAMENTO	Region 3												
95851	SACRAMENTO	Region 3												
95852	SACRAMENTO	Region 3												
95853	SACRAMENTO	Region 3												
95860	SACRAMENTO	Region 3												
95864	SACRAMENTO	Region 3												
95865	SACRAMENTO	Region 3												
95866	SACRAMENTO	Region 3												
95867	SACRAMENTO	Region 3												
95887	SACRAMENTO	Region 3												
95894	SACRAMENTO	Region 3												
95899	SACRAMENTO	Region 3												
95023	SAN BENITO	Region 9												
95024	SAN BENITO	Region 9												
95043	SAN BENITO	Region 9												
95045	SAN BENITO	Region 9												
95075	SAN BENITO	Region 9												
91701	SAN BERNARDINO	Region 17												
91708	SAN BERNARDINO	Region 17												
91709	SAN BERNARDINO	Region 17												
91710	SAN BERNARDINO	Region 17												
91729	SAN BERNARDINO	Region 17												
91730	SAN BERNARDINO	Region 17												
91737	SAN BERNARDINO	Region 17												
91739	SAN BERNARDINO	Region 17												
91743	SAN BERNARDINO	Region 17												
91758	SAN BERNARDINO	Region 17												
91761	SAN BERNARDINO	Region 17												
91762	SAN BERNARDINO	Region 17												
91763	SAN BERNARDINO	Region 17												
91764	SAN BERNARDINO	Region 17												
91784	SAN BERNARDINO	Region 17												
91785	SAN BERNARDINO	Region 17												
91786	SAN BERNARDINO	Region 17												
91798	SAN BERNARDINO	Region 17												
92242	SAN BERNARDINO	Region 17												
92252	SAN BERNARDINO	Region 17												
92256	SAN BERNARDINO	Region 17												
92267	SAN BERNARDINO	Region 17												
92268	SAN BERNARDINO	Region 17												
92277	SAN BERNARDINO	Region 17												
92278	SAN BERNARDINO	Region 17												
92280	SAN BERNARDINO	Region 17												
92284	SAN BERNARDINO	Region 17												
92285	SAN BERNARDINO	Region 17												
92286	SAN BERNARDINO	Region 17												
92301	SAN BERNARDINO	Region 17												
92304	SAN BERNARDINO	Region 17												
92305	SAN BERNARDINO	Region 17												
92307	SAN BERNARDINO	Region 17												
92308	SAN BERNARDINO	Region 17												
92309	SAN BERNARDINO	Region 17												
92310	SAN BERNARDINO	Region 17												
92311	SAN BERNARDINO	Region 17												
92312	SAN BERNARDINO	Region 17												
92313	SAN BERNARDINO	Region 17												
92314	SAN BERNARDINO	Region 17												
92315	SAN BERNARDINO	Region 17												
92316	SAN BERNARDINO	Region 17												
92317	SAN BERNARDINO	Region 17												
92318	SAN BERNARDINO	Region 17												
92321	SAN BERNARDINO	Region 17												
92322	SAN BERNARDINO	Region 17												
92323	SAN BERNARDINO	Region 17												
92324	SAN BERNARDINO	Region 17												
92325	SAN BERNARDINO	Region 17												
92326	SAN BERNARDINO	Region 17												
92327	SAN BERNARDINO	Region 17												
92329	SAN BERNARDINO	Region 17												
92331	SAN BERNARDINO	Region 17												
92332	SAN BERNARDINO	Region 17												
92333	SAN BERNARDINO	Region 17												
92334	SAN BERNARDINO	Region 17												
92335	SAN BERNARDINO	Region 17												
92336	SAN BERNARDINO	Region 17												
92337	SAN BERNARDINO	Region 17												
92338	SAN BERNARDINO	Region 17												
92339	SAN BERNARDINO	Region 17												
92340	SAN BERNARDINO	Region 17												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
92341	SAN BERNARDINO	Region 17												
92342	SAN BERNARDINO	Region 17												
92344	SAN BERNARDINO	Region 17												
92345	SAN BERNARDINO	Region 17												
92346	SAN BERNARDINO	Region 17												
92347	SAN BERNARDINO	Region 17												
92350	SAN BERNARDINO	Region 17												
92352	SAN BERNARDINO	Region 17												
92354	SAN BERNARDINO	Region 17												
92356	SAN BERNARDINO	Region 17												
92357	SAN BERNARDINO	Region 17												
92358	SAN BERNARDINO	Region 17												
92359	SAN BERNARDINO	Region 17												
92363	SAN BERNARDINO	Region 17												
92364	SAN BERNARDINO	Region 17												
92365	SAN BERNARDINO	Region 17												
92366	SAN BERNARDINO	Region 17												
92368	SAN BERNARDINO	Region 17												
92369	SAN BERNARDINO	Region 17												
92371	SAN BERNARDINO	Region 17												
92372	SAN BERNARDINO	Region 17												
92373	SAN BERNARDINO	Region 17												
92374	SAN BERNARDINO	Region 17												
92375	SAN BERNARDINO	Region 17												
92376	SAN BERNARDINO	Region 17												
92377	SAN BERNARDINO	Region 17												
92378	SAN BERNARDINO	Region 17												
92382	SAN BERNARDINO	Region 17												
92385	SAN BERNARDINO	Region 17												
92386	SAN BERNARDINO	Region 17												
92391	SAN BERNARDINO	Region 17												
92392	SAN BERNARDINO	Region 17												
92393	SAN BERNARDINO	Region 17												
92394	SAN BERNARDINO	Region 17												
92395	SAN BERNARDINO	Region 17												
92397	SAN BERNARDINO	Region 17												
92398	SAN BERNARDINO	Region 17												
92399	SAN BERNARDINO	Region 17												
92401	SAN BERNARDINO	Region 17												
92402	SAN BERNARDINO	Region 17												
92403	SAN BERNARDINO	Region 17												
92404	SAN BERNARDINO	Region 17												
92405	SAN BERNARDINO	Region 17												
92406	SAN BERNARDINO	Region 17												
92407	SAN BERNARDINO	Region 17												
92408	SAN BERNARDINO	Region 17												
92410	SAN BERNARDINO	Region 17												
92411	SAN BERNARDINO	Region 17												
92412	SAN BERNARDINO	Region 17												
92413	SAN BERNARDINO	Region 17												
92414	SAN BERNARDINO	Region 17												
92415	SAN BERNARDINO	Region 17												
92418	SAN BERNARDINO	Region 17												
92423	SAN BERNARDINO	Region 17												
92424	SAN BERNARDINO	Region 17												
92427	SAN BERNARDINO	Region 17												
93558	SAN BERNARDINO	Region 17												
93562	SAN BERNARDINO	Region 17												
93592	SAN BERNARDINO	Region 17												
91901	SAN DIEGO	Region 19												
91902	SAN DIEGO	Region 19												
91903	SAN DIEGO	Region 19												
91905	SAN DIEGO	Region 19												
91906	SAN DIEGO	Region 19												
91908	SAN DIEGO	Region 19												
91909	SAN DIEGO	Region 19												
91910	SAN DIEGO	Region 19												
91911	SAN DIEGO	Region 19												
91912	SAN DIEGO	Region 19												
91913	SAN DIEGO	Region 19												
91914	SAN DIEGO	Region 19												
91915	SAN DIEGO	Region 19												
91916	SAN DIEGO	Region 19												
91917	SAN DIEGO	Region 19												
91921	SAN DIEGO	Region 19												
91931	SAN DIEGO	Region 19												
91932	SAN DIEGO	Region 19												
91933	SAN DIEGO	Region 19												
91934	SAN DIEGO	Region 19												
91935	SAN DIEGO	Region 19												
91941	SAN DIEGO	Region 19												
91942	SAN DIEGO	Region 19												
91943	SAN DIEGO	Region 19												
91944	SAN DIEGO	Region 19												
91945	SAN DIEGO	Region 19												
91946	SAN DIEGO	Region 19												
91947	SAN DIEGO	Region 19												
91948	SAN DIEGO	Region 19												
91950	SAN DIEGO	Region 19												
91951	SAN DIEGO	Region 19												
91962	SAN DIEGO	Region 19												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
91963	SAN DIEGO	Region 19												
91976	SAN DIEGO	Region 19												
91977	SAN DIEGO	Region 19												
91978	SAN DIEGO	Region 19												
91979	SAN DIEGO	Region 19												
91980	SAN DIEGO	Region 19												
91987	SAN DIEGO	Region 19												
91990	SAN DIEGO	Region 19												
92003	SAN DIEGO	Region 19												
92004	SAN DIEGO	Region 19												
92007	SAN DIEGO	Region 19												
92008	SAN DIEGO	Region 19												
92009	SAN DIEGO	Region 19												
92010	SAN DIEGO	Region 19												
92011	SAN DIEGO	Region 19												
92013	SAN DIEGO	Region 19												
92014	SAN DIEGO	Region 19												
92018	SAN DIEGO	Region 19												
92019	SAN DIEGO	Region 19												
92020	SAN DIEGO	Region 19												
92021	SAN DIEGO	Region 19												
92022	SAN DIEGO	Region 19												
92023	SAN DIEGO	Region 19												
92024	SAN DIEGO	Region 19												
92025	SAN DIEGO	Region 19												
92026	SAN DIEGO	Region 19												
92027	SAN DIEGO	Region 19												
92028	SAN DIEGO	Region 19												
92029	SAN DIEGO	Region 19												
92030	SAN DIEGO	Region 19												
92033	SAN DIEGO	Region 19												
92036	SAN DIEGO	Region 19												
92037	SAN DIEGO	Region 19												
92038	SAN DIEGO	Region 19												
92039	SAN DIEGO	Region 19												
92040	SAN DIEGO	Region 19												
92046	SAN DIEGO	Region 19												
92049	SAN DIEGO	Region 19												
92051	SAN DIEGO	Region 19												
92052	SAN DIEGO	Region 19												
92054	SAN DIEGO	Region 19												
92055	SAN DIEGO	Region 19												
92056	SAN DIEGO	Region 19												
92057	SAN DIEGO	Region 19												
92058	SAN DIEGO	Region 19												
92059	SAN DIEGO	Region 19												
92060	SAN DIEGO	Region 19												
92061	SAN DIEGO	Region 19												
92064	SAN DIEGO	Region 19												
92065	SAN DIEGO	Region 19												
92066	SAN DIEGO	Region 19												
92067	SAN DIEGO	Region 19												
92068	SAN DIEGO	Region 19												
92069	SAN DIEGO	Region 19												
92070	SAN DIEGO	Region 19												
92071	SAN DIEGO	Region 19												
92072	SAN DIEGO	Region 19												
92074	SAN DIEGO	Region 19												
92075	SAN DIEGO	Region 19												
92078	SAN DIEGO	Region 19												
92079	SAN DIEGO	Region 19												
92081	SAN DIEGO	Region 19												
92082	SAN DIEGO	Region 19												
92083	SAN DIEGO	Region 19												
92084	SAN DIEGO	Region 19												
92085	SAN DIEGO	Region 19												
92086	SAN DIEGO	Region 19												
92088	SAN DIEGO	Region 19												
92090	SAN DIEGO	Region 19												
92091	SAN DIEGO	Region 19												
92092	SAN DIEGO	Region 19												
92093	SAN DIEGO	Region 19												
92096	SAN DIEGO	Region 19												
92101	SAN DIEGO	Region 19												
92102	SAN DIEGO	Region 19												
92103	SAN DIEGO	Region 19												
92104	SAN DIEGO	Region 19												
92105	SAN DIEGO	Region 19												
92106	SAN DIEGO	Region 19												
92107	SAN DIEGO	Region 19												
92108	SAN DIEGO	Region 19												
92109	SAN DIEGO	Region 19												
92110	SAN DIEGO	Region 19												
92111	SAN DIEGO	Region 19												
92112	SAN DIEGO	Region 19												
92113	SAN DIEGO	Region 19												
92114	SAN DIEGO	Region 19												
92115	SAN DIEGO	Region 19												
92116	SAN DIEGO	Region 19												
92117	SAN DIEGO	Region 19												
92118	SAN DIEGO	Region 19												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
92119	SAN DIEGO	Region 19												
92120	SAN DIEGO	Region 19												
92121	SAN DIEGO	Region 19												
92122	SAN DIEGO	Region 19												
92123	SAN DIEGO	Region 19												
92124	SAN DIEGO	Region 19												
92126	SAN DIEGO	Region 19												
92127	SAN DIEGO	Region 19												
92128	SAN DIEGO	Region 19												
92129	SAN DIEGO	Region 19												
92130	SAN DIEGO	Region 19												
92131	SAN DIEGO	Region 19												
92132	SAN DIEGO	Region 19												
92133	SAN DIEGO	Region 19												
92134	SAN DIEGO	Region 19												
92135	SAN DIEGO	Region 19												
92136	SAN DIEGO	Region 19												
92137	SAN DIEGO	Region 19												
92138	SAN DIEGO	Region 19												
92139	SAN DIEGO	Region 19												
92140	SAN DIEGO	Region 19												
92142	SAN DIEGO	Region 19												
92143	SAN DIEGO	Region 19												
92145	SAN DIEGO	Region 19												
92147	SAN DIEGO	Region 19												
92149	SAN DIEGO	Region 19												
92150	SAN DIEGO	Region 19												
92152	SAN DIEGO	Region 19												
92153	SAN DIEGO	Region 19												
92154	SAN DIEGO	Region 19												
92155	SAN DIEGO	Region 19												
92158	SAN DIEGO	Region 19												
92159	SAN DIEGO	Region 19												
92160	SAN DIEGO	Region 19												
92161	SAN DIEGO	Region 19												
92162	SAN DIEGO	Region 19												
92163	SAN DIEGO	Region 19												
92164	SAN DIEGO	Region 19												
92165	SAN DIEGO	Region 19												
92166	SAN DIEGO	Region 19												
92167	SAN DIEGO	Region 19												
92168	SAN DIEGO	Region 19												
92169	SAN DIEGO	Region 19												
92170	SAN DIEGO	Region 19												
92171	SAN DIEGO	Region 19												
92172	SAN DIEGO	Region 19												
92173	SAN DIEGO	Region 19												
92174	SAN DIEGO	Region 19												
92175	SAN DIEGO	Region 19												
92176	SAN DIEGO	Region 19												
92177	SAN DIEGO	Region 19												
92178	SAN DIEGO	Region 19												
92179	SAN DIEGO	Region 19												
92182	SAN DIEGO	Region 19												
92184	SAN DIEGO	Region 19												
92186	SAN DIEGO	Region 19												
92187	SAN DIEGO	Region 19												
92190	SAN DIEGO	Region 19												
92191	SAN DIEGO	Region 19												
92192	SAN DIEGO	Region 19												
92193	SAN DIEGO	Region 19												
92194	SAN DIEGO	Region 19												
92195	SAN DIEGO	Region 19												
92196	SAN DIEGO	Region 19												
92197	SAN DIEGO	Region 19												
92198	SAN DIEGO	Region 19												
92199	SAN DIEGO	Region 19												
94101	SAN FRANCISCO	Region 4												
94102	SAN FRANCISCO	Region 4												
94103	SAN FRANCISCO	Region 4												
94104	SAN FRANCISCO	Region 4												
94105	SAN FRANCISCO	Region 4												
94106	SAN FRANCISCO	Region 4												
94107	SAN FRANCISCO	Region 4												
94108	SAN FRANCISCO	Region 4												
94109	SAN FRANCISCO	Region 4												
94110	SAN FRANCISCO	Region 4												
94111	SAN FRANCISCO	Region 4												
94112	SAN FRANCISCO	Region 4												
94114	SAN FRANCISCO	Region 4												
94115	SAN FRANCISCO	Region 4												
94116	SAN FRANCISCO	Region 4												
94117	SAN FRANCISCO	Region 4												
94118	SAN FRANCISCO	Region 4												
94119	SAN FRANCISCO	Region 4												
94120	SAN FRANCISCO	Region 4												
94121	SAN FRANCISCO	Region 4												
94122	SAN FRANCISCO	Region 4												
94123	SAN FRANCISCO	Region 4												
94124	SAN FRANCISCO	Region 4												
94125	SAN FRANCISCO	Region 4												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
94126	SAN FRANCISCO	Region 4												
94127	SAN FRANCISCO	Region 4												
94129	SAN FRANCISCO	Region 4												
94130	SAN FRANCISCO	Region 4												
94131	SAN FRANCISCO	Region 4												
94132	SAN FRANCISCO	Region 4												
94133	SAN FRANCISCO	Region 4												
94134	SAN FRANCISCO	Region 4												
94135	SAN FRANCISCO	Region 4												
94136	SAN FRANCISCO	Region 4												
94137	SAN FRANCISCO	Region 4												
94138	SAN FRANCISCO	Region 4												
94139	SAN FRANCISCO	Region 4												
94140	SAN FRANCISCO	Region 4												
94141	SAN FRANCISCO	Region 4												
94142	SAN FRANCISCO	Region 4												
94143	SAN FRANCISCO	Region 4												
94144	SAN FRANCISCO	Region 4												
94145	SAN FRANCISCO	Region 4												
94146	SAN FRANCISCO	Region 4												
94147	SAN FRANCISCO	Region 4												
94150	SAN FRANCISCO	Region 4												
94151	SAN FRANCISCO	Region 4												
94152	SAN FRANCISCO	Region 4												
94153	SAN FRANCISCO	Region 4												
94154	SAN FRANCISCO	Region 4												
94155	SAN FRANCISCO	Region 4												
94156	SAN FRANCISCO	Region 4												
94158	SAN FRANCISCO	Region 4												
94159	SAN FRANCISCO	Region 4												
94160	SAN FRANCISCO	Region 4												
94161	SAN FRANCISCO	Region 4												
94162	SAN FRANCISCO	Region 4												
94163	SAN FRANCISCO	Region 4												
94164	SAN FRANCISCO	Region 4												
94171	SAN FRANCISCO	Region 4												
94172	SAN FRANCISCO	Region 4												
94175	SAN FRANCISCO	Region 4												
94177	SAN FRANCISCO	Region 4												
94188	SAN FRANCISCO	Region 4												
94199	SAN FRANCISCO	Region 4												
95201	SAN JOAQUIN	Region 10												
95202	SAN JOAQUIN	Region 10												
95203	SAN JOAQUIN	Region 10												
95204	SAN JOAQUIN	Region 10												
95205	SAN JOAQUIN	Region 10												
95206	SAN JOAQUIN	Region 10												
95207	SAN JOAQUIN	Region 10												
95208	SAN JOAQUIN	Region 10												
95209	SAN JOAQUIN	Region 10												
95210	SAN JOAQUIN	Region 10												
95211	SAN JOAQUIN	Region 10												
95212	SAN JOAQUIN	Region 10												
95213	SAN JOAQUIN	Region 10												
95215	SAN JOAQUIN	Region 10												
95219	SAN JOAQUIN	Region 10												
95220	SAN JOAQUIN	Region 10												
95227	SAN JOAQUIN	Region 10												
95230	SAN JOAQUIN	Region 10												
95231	SAN JOAQUIN	Region 10												
95234	SAN JOAQUIN	Region 10												
95236	SAN JOAQUIN	Region 10												
95237	SAN JOAQUIN	Region 10												
95240	SAN JOAQUIN	Region 10												
95241	SAN JOAQUIN	Region 10												
95242	SAN JOAQUIN	Region 10												
95253	SAN JOAQUIN	Region 10												
95258	SAN JOAQUIN	Region 10												
95267	SAN JOAQUIN	Region 10												
95269	SAN JOAQUIN	Region 10												
95296	SAN JOAQUIN	Region 10												
95297	SAN JOAQUIN	Region 10												
95304	SAN JOAQUIN	Region 10												
95320	SAN JOAQUIN	Region 10												
95330	SAN JOAQUIN	Region 10												
95336	SAN JOAQUIN	Region 10												
95337	SAN JOAQUIN	Region 10												
95366	SAN JOAQUIN	Region 10												
95376	SAN JOAQUIN	Region 10												
95377	SAN JOAQUIN	Region 10												
95378	SAN JOAQUIN	Region 10												
95385	SAN JOAQUIN	Region 10												
95391	SAN JOAQUIN	Region 10												
95686	SAN JOAQUIN	Region 10												
93401	SAN LUIS OBISPO	Region 12												
93402	SAN LUIS OBISPO	Region 12												
93403	SAN LUIS OBISPO	Region 12												
93405	SAN LUIS OBISPO	Region 12												
93406	SAN LUIS OBISPO	Region 12												
93407	SAN LUIS OBISPO	Region 12												
93408	SAN LUIS OBISPO	Region 12												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93409	SAN LUIS OBISPO	Region 12												
93410	SAN LUIS OBISPO	Region 12												
93412	SAN LUIS OBISPO	Region 12												
93420	SAN LUIS OBISPO	Region 12												
93421	SAN LUIS OBISPO	Region 12												
93422	SAN LUIS OBISPO	Region 12												
93423	SAN LUIS OBISPO	Region 12												
93424	SAN LUIS OBISPO	Region 12												
93428	SAN LUIS OBISPO	Region 12												
93430	SAN LUIS OBISPO	Region 12												
93432	SAN LUIS OBISPO	Region 12												
93433	SAN LUIS OBISPO	Region 12												
93435	SAN LUIS OBISPO	Region 12												
93442	SAN LUIS OBISPO	Region 12												
93443	SAN LUIS OBISPO	Region 12												
93444	SAN LUIS OBISPO	Region 12												
93445	SAN LUIS OBISPO	Region 12												
93446	SAN LUIS OBISPO	Region 12												
93447	SAN LUIS OBISPO	Region 12												
93448	SAN LUIS OBISPO	Region 12												
93449	SAN LUIS OBISPO	Region 12												
93451	SAN LUIS OBISPO	Region 12												
93452	SAN LUIS OBISPO	Region 12												
93453	SAN LUIS OBISPO	Region 12												
93461	SAN LUIS OBISPO	Region 12												
93465	SAN LUIS OBISPO	Region 12												
93475	SAN LUIS OBISPO	Region 12												
93483	SAN LUIS OBISPO	Region 12												
94002	SAN MATEO	Region 8												
94005	SAN MATEO	Region 8												
94010	SAN MATEO	Region 8												
94011	SAN MATEO	Region 8												
94013	SAN MATEO	Region 8												
94014	SAN MATEO	Region 8												
94015	SAN MATEO	Region 8												
94016	SAN MATEO	Region 8												
94017	SAN MATEO	Region 8												
94018	SAN MATEO	Region 8												
94019	SAN MATEO	Region 8												
94020	SAN MATEO	Region 8												
94021	SAN MATEO	Region 8												
94025	SAN MATEO	Region 8												
94026	SAN MATEO	Region 8												
94027	SAN MATEO	Region 8												
94028	SAN MATEO	Region 8												
94030	SAN MATEO	Region 8												
94037	SAN MATEO	Region 8												
94038	SAN MATEO	Region 8												
94044	SAN MATEO	Region 8												
94060	SAN MATEO	Region 8												
94061	SAN MATEO	Region 8												
94062	SAN MATEO	Region 8												
94063	SAN MATEO	Region 8												
94064	SAN MATEO	Region 8												
94065	SAN MATEO	Region 8												
94066	SAN MATEO	Region 8												
94070	SAN MATEO	Region 8												
94074	SAN MATEO	Region 8												
94080	SAN MATEO	Region 8												
94083	SAN MATEO	Region 8												
94128	SAN MATEO	Region 8												
94401	SAN MATEO	Region 8												
94402	SAN MATEO	Region 8												
94403	SAN MATEO	Region 8												
94404	SAN MATEO	Region 8												
94497	SAN MATEO	Region 8												
93013	SANTA BARBARA	Region 12												
93014	SANTA BARBARA	Region 12												
93067	SANTA BARBARA	Region 12												
93101	SANTA BARBARA	Region 12												
93102	SANTA BARBARA	Region 12												
93103	SANTA BARBARA	Region 12												
93105	SANTA BARBARA	Region 12												
93106	SANTA BARBARA	Region 12												
93107	SANTA BARBARA	Region 12												
93108	SANTA BARBARA	Region 12												
93109	SANTA BARBARA	Region 12												
93110	SANTA BARBARA	Region 12												
93111	SANTA BARBARA	Region 12												
93116	SANTA BARBARA	Region 12												
93117	SANTA BARBARA	Region 12												
93118	SANTA BARBARA	Region 12												
93120	SANTA BARBARA	Region 12												
93121	SANTA BARBARA	Region 12												
93130	SANTA BARBARA	Region 12												
93140	SANTA BARBARA	Region 12												
93150	SANTA BARBARA	Region 12												
93160	SANTA BARBARA	Region 12												
93190	SANTA BARBARA	Region 12												
93199	SANTA BARBARA	Region 12												
93254	SANTA BARBARA	Region 12												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93427	SANTA BARBARA	Region 12												
93429	SANTA BARBARA	Region 12												
93434	SANTA BARBARA	Region 12												
93436	SANTA BARBARA	Region 12												
93437	SANTA BARBARA	Region 12												
93438	SANTA BARBARA	Region 12												
93496	SANTA BARBARA	Region 12												
93440	SANTA BARBARA	Region 12												
93441	SANTA BARBARA	Region 12												
93454	SANTA BARBARA	Region 12												
93455	SANTA BARBARA	Region 12												
93456	SANTA BARBARA	Region 12												
93457	SANTA BARBARA	Region 12												
93458	SANTA BARBARA	Region 12												
93460	SANTA BARBARA	Region 12												
93463	SANTA BARBARA	Region 12												
93464	SANTA BARBARA	Region 12												
94022	SANTA CLARA	Region 7												
94023	SANTA CLARA	Region 7												
94024	SANTA CLARA	Region 7												
94035	SANTA CLARA	Region 7												
94039	SANTA CLARA	Region 7												
94040	SANTA CLARA	Region 7												
94041	SANTA CLARA	Region 7												
94042	SANTA CLARA	Region 7												
94043	SANTA CLARA	Region 7												
94085	SANTA CLARA	Region 7												
94086	SANTA CLARA	Region 7												
94087	SANTA CLARA	Region 7												
94088	SANTA CLARA	Region 7												
94089	SANTA CLARA	Region 7												
94301	SANTA CLARA	Region 7												
94302	SANTA CLARA	Region 7												
94303	SANTA CLARA	Region 7												
94304	SANTA CLARA	Region 7												
94305	SANTA CLARA	Region 7												
94306	SANTA CLARA	Region 7												
94309	SANTA CLARA	Region 7												
95002	SANTA CLARA	Region 7												
95008	SANTA CLARA	Region 7												
95009	SANTA CLARA	Region 7												
95011	SANTA CLARA	Region 7												
95013	SANTA CLARA	Region 7												
95014	SANTA CLARA	Region 7												
95015	SANTA CLARA	Region 7												
95020	SANTA CLARA	Region 7												
95021	SANTA CLARA	Region 7												
95026	SANTA CLARA	Region 7												
95030	SANTA CLARA	Region 7												
95031	SANTA CLARA	Region 7												
95032	SANTA CLARA	Region 7												
95035	SANTA CLARA	Region 7												
95036	SANTA CLARA	Region 7												
95037	SANTA CLARA	Region 7												
95038	SANTA CLARA	Region 7												
95042	SANTA CLARA	Region 7												
95044	SANTA CLARA	Region 7												
95046	SANTA CLARA	Region 7												
95050	SANTA CLARA	Region 7												
95051	SANTA CLARA	Region 7												
95052	SANTA CLARA	Region 7												
95053	SANTA CLARA	Region 7												
95054	SANTA CLARA	Region 7												
95055	SANTA CLARA	Region 7												
95056	SANTA CLARA	Region 7												
95070	SANTA CLARA	Region 7												
95071	SANTA CLARA	Region 7												
95101	SANTA CLARA	Region 7												
95103	SANTA CLARA	Region 7												
95106	SANTA CLARA	Region 7												
95108	SANTA CLARA	Region 7												
95109	SANTA CLARA	Region 7												
95110	SANTA CLARA	Region 7												
95111	SANTA CLARA	Region 7												
95112	SANTA CLARA	Region 7												
95113	SANTA CLARA	Region 7												
95115	SANTA CLARA	Region 7												
95116	SANTA CLARA	Region 7												
95117	SANTA CLARA	Region 7												
95118	SANTA CLARA	Region 7												
95119	SANTA CLARA	Region 7												
95120	SANTA CLARA	Region 7												
95121	SANTA CLARA	Region 7												
95122	SANTA CLARA	Region 7												
95123	SANTA CLARA	Region 7												
95124	SANTA CLARA	Region 7												
95125	SANTA CLARA	Region 7												
95126	SANTA CLARA	Region 7												
95127	SANTA CLARA	Region 7												
95128	SANTA CLARA	Region 7												
95129	SANTA CLARA	Region 7												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95130	SANTA CLARA	Region 7												
95131	SANTA CLARA	Region 7												
95132	SANTA CLARA	Region 7												
95133	SANTA CLARA	Region 7												
95134	SANTA CLARA	Region 7												
95135	SANTA CLARA	Region 7												
95136	SANTA CLARA	Region 7												
95138	SANTA CLARA	Region 7												
95139	SANTA CLARA	Region 7												
95140	SANTA CLARA	Region 7												
95141	SANTA CLARA	Region 7												
95148	SANTA CLARA	Region 7												
95150	SANTA CLARA	Region 7												
95151	SANTA CLARA	Region 7												
95152	SANTA CLARA	Region 7												
95153	SANTA CLARA	Region 7												
95154	SANTA CLARA	Region 7												
95155	SANTA CLARA	Region 7												
95156	SANTA CLARA	Region 7												
95157	SANTA CLARA	Region 7												
95158	SANTA CLARA	Region 7												
95159	SANTA CLARA	Region 7												
95160	SANTA CLARA	Region 7												
95161	SANTA CLARA	Region 7												
95164	SANTA CLARA	Region 7												
95170	SANTA CLARA	Region 7												
95172	SANTA CLARA	Region 7												
95173	SANTA CLARA	Region 7												
95190	SANTA CLARA	Region 7												
95191	SANTA CLARA	Region 7												
95192	SANTA CLARA	Region 7												
95193	SANTA CLARA	Region 7												
95194	SANTA CLARA	Region 7												
95196	SANTA CLARA	Region 7												
95001	SANTA CRUZ	Region 9												
95003	SANTA CRUZ	Region 9												
95005	SANTA CRUZ	Region 9												
95006	SANTA CRUZ	Region 9												
95007	SANTA CRUZ	Region 9												
95010	SANTA CRUZ	Region 9												
95017	SANTA CRUZ	Region 9												
95018	SANTA CRUZ	Region 9												
95019	SANTA CRUZ	Region 9												
95033	SANTA CRUZ	Region 9												
95041	SANTA CRUZ	Region 9												
95060	SANTA CRUZ	Region 9												
95061	SANTA CRUZ	Region 9												
95062	SANTA CRUZ	Region 9												
95063	SANTA CRUZ	Region 9												
95064	SANTA CRUZ	Region 9												
95065	SANTA CRUZ	Region 9												
95066	SANTA CRUZ	Region 9												
95067	SANTA CRUZ	Region 9												
95073	SANTA CRUZ	Region 9												
95076	SANTA CRUZ	Region 9												
95077	SANTA CRUZ	Region 9												
96001	SHASTA	Region 1												
96002	SHASTA	Region 1												
96003	SHASTA	Region 1												
96007	SHASTA	Region 1												
96008	SHASTA	Region 1												
96011	SHASTA	Region 1												
96013	SHASTA	Region 1												
96016	SHASTA	Region 1												
96017	SHASTA	Region 1												
96019	SHASTA	Region 1												
96022	SHASTA	Region 1												
96028	SHASTA	Region 1												
96033	SHASTA	Region 1												
96040	SHASTA	Region 1												
96047	SHASTA	Region 1												
96049	SHASTA	Region 1												
96051	SHASTA	Region 1												
96056	SHASTA	Region 1												
96062	SHASTA	Region 1												
96065	SHASTA	Region 1												
96069	SHASTA	Region 1												
96070	SHASTA	Region 1												
96071	SHASTA	Region 1												
96073	SHASTA	Region 1												
96076	SHASTA	Region 1												
96079	SHASTA	Region 1												
96084	SHASTA	Region 1												
96087	SHASTA	Region 1												
96088	SHASTA	Region 1												
96089	SHASTA	Region 1												
96095	SHASTA	Region 1												
96096	SHASTA	Region 1												
96099	SHASTA	Region 1												
95910	SIERRA	Region 1												
95936	SIERRA	Region 1												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95944	SIERRA	Region 1												
96118	SIERRA	Region 1												
96124	SIERRA	Region 1												
96125	SIERRA	Region 1												
96126	SIERRA	Region 1												
95568	SISKIYOU	Region 1												
96014	SISKIYOU	Region 1												
96023	SISKIYOU	Region 1												
96025	SISKIYOU	Region 1												
96027	SISKIYOU	Region 1												
96031	SISKIYOU	Region 1												
96032	SISKIYOU	Region 1												
96034	SISKIYOU	Region 1												
96037	SISKIYOU	Region 1												
96038	SISKIYOU	Region 1												
96039	SISKIYOU	Region 1												
96044	SISKIYOU	Region 1												
96050	SISKIYOU	Region 1												
96057	SISKIYOU	Region 1												
96058	SISKIYOU	Region 1												
96064	SISKIYOU	Region 1												
96067	SISKIYOU	Region 1												
96085	SISKIYOU	Region 1												
96086	SISKIYOU	Region 1												
96094	SISKIYOU	Region 1												
96097	SISKIYOU	Region 1												
96134	SISKIYOU	Region 1												
94510	SOLANO	Region 2												
94512	SOLANO	Region 2												
94533	SOLANO	Region 2												
94534	SOLANO	Region 2												
94535	SOLANO	Region 2												
94571	SOLANO	Region 2												
94585	SOLANO	Region 2												
94589	SOLANO	Region 2												
94590	SOLANO	Region 2												
94591	SOLANO	Region 2												
94592	SOLANO	Region 2												
95620	SOLANO	Region 2												
95625	SOLANO	Region 2												
95687	SOLANO	Region 2												
95688	SOLANO	Region 2												
95696	SOLANO	Region 2												
94922	SONOMA	Region 2												
94923	SONOMA	Region 2												
94926	SONOMA	Region 2												
94927	SONOMA	Region 2												
94928	SONOMA	Region 2												
94931	SONOMA	Region 2												
94951	SONOMA	Region 2												
94952	SONOMA	Region 2												
94953	SONOMA	Region 2												
94954	SONOMA	Region 2												
94955	SONOMA	Region 2												
94972	SONOMA	Region 2												
94975	SONOMA	Region 2												
94999	SONOMA	Region 2												
95401	SONOMA	Region 2												
95402	SONOMA	Region 2												
95403	SONOMA	Region 2												
95404	SONOMA	Region 2												
95405	SONOMA	Region 2												
95406	SONOMA	Region 2												
95407	SONOMA	Region 2												
95409	SONOMA	Region 2												
95412	SONOMA	Region 2												
95416	SONOMA	Region 2												
95419	SONOMA	Region 2												
95421	SONOMA	Region 2												
95425	SONOMA	Region 2												
95430	SONOMA	Region 2												
95431	SONOMA	Region 2												
95433	SONOMA	Region 2												
95436	SONOMA	Region 2												
95439	SONOMA	Region 2												
95441	SONOMA	Region 2												
95442	SONOMA	Region 2												
95444	SONOMA	Region 2												
95446	SONOMA	Region 2												
95448	SONOMA	Region 2												
95450	SONOMA	Region 2												
95452	SONOMA	Region 2												
95462	SONOMA	Region 2												
95465	SONOMA	Region 2												
95471	SONOMA	Region 2												
95472	SONOMA	Region 2												
95473	SONOMA	Region 2												
95476	SONOMA	Region 2												
95480	SONOMA	Region 2												
95486	SONOMA	Region 2												
95487	SONOMA	Region 2												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95492	SONOMA	Region 2												
95497	SONOMA	Region 2												
95307	STANISLAUS	Region 10												
95313	STANISLAUS	Region 10												
95316	STANISLAUS	Region 10												
95319	STANISLAUS	Region 10												
95323	STANISLAUS	Region 10												
95326	STANISLAUS	Region 10												
95328	STANISLAUS	Region 10												
95329	STANISLAUS	Region 10												
95350	STANISLAUS	Region 10												
95351	STANISLAUS	Region 10												
95352	STANISLAUS	Region 10												
95353	STANISLAUS	Region 10												
95354	STANISLAUS	Region 10												
95355	STANISLAUS	Region 10												
95356	STANISLAUS	Region 10												
95357	STANISLAUS	Region 10												
95358	STANISLAUS	Region 10												
95360	STANISLAUS	Region 10												
95361	STANISLAUS	Region 10												
95363	STANISLAUS	Region 10												
95367	STANISLAUS	Region 10												
95368	STANISLAUS	Region 10												
95380	STANISLAUS	Region 10												
95381	STANISLAUS	Region 10												
95382	STANISLAUS	Region 10												
95386	STANISLAUS	Region 10												
95387	STANISLAUS	Region 10												
95397	STANISLAUS	Region 10												
95659	SUTTER	Region 1												
95668	SUTTER	Region 1												
95674	SUTTER	Region 1												
95676	SUTTER	Region 1												
95953	SUTTER	Region 1												
95957	SUTTER	Region 1												
95982	SUTTER	Region 1												
95991	SUTTER	Region 1												
95992	SUTTER	Region 1												
95993	SUTTER	Region 1												
96021	TEHAMA	Region 1												
96029	TEHAMA	Region 1												
96035	TEHAMA	Region 1												
96055	TEHAMA	Region 1												
96059	TEHAMA	Region 1												
96061	TEHAMA	Region 1												
96063	TEHAMA	Region 1												
96074	TEHAMA	Region 1												
96075	TEHAMA	Region 1												
96078	TEHAMA	Region 1												
96080	TEHAMA	Region 1												
96090	TEHAMA	Region 1												
96092	TEHAMA	Region 1												
95527	TRINITY	Region 1												
95552	TRINITY	Region 1												
95563	TRINITY	Region 1												
95595	TRINITY	Region 1												
96010	TRINITY	Region 1												
96024	TRINITY	Region 1												
96041	TRINITY	Region 1												
96046	TRINITY	Region 1												
96048	TRINITY	Region 1												
96052	TRINITY	Region 1												
96091	TRINITY	Region 1												
96093	TRINITY	Region 1												
93201	TULARE	Region 10												
93207	TULARE	Region 10												
93208	TULARE	Region 10												
93218	TULARE	Region 10												
93219	TULARE	Region 10												
93221	TULARE	Region 10												
93223	TULARE	Region 10												
93227	TULARE	Region 10												
93235	TULARE	Region 10												
93237	TULARE	Region 10												
93244	TULARE	Region 10												
93247	TULARE	Region 10												
93256	TULARE	Region 10												
93257	TULARE	Region 10												
93258	TULARE	Region 10												
93260	TULARE	Region 10												
93261	TULARE	Region 10												
93262	TULARE	Region 10												
93265	TULARE	Region 10												
93267	TULARE	Region 10												
93270	TULARE	Region 10												
93271	TULARE	Region 10												
93272	TULARE	Region 10												
93274	TULARE	Region 10												
93275	TULARE	Region 10												
93277	TULARE	Region 10												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
93278	TULARE	Region 10												
93279	TULARE	Region 10												
93282	TULARE	Region 10												
93286	TULARE	Region 10												
93290	TULARE	Region 10												
93291	TULARE	Region 10												
93292	TULARE	Region 10												
93293	TULARE	Region 10												
93603	TULARE	Region 10												
93615	TULARE	Region 10												
93618	TULARE	Region 10												
93633	TULARE	Region 10												
93647	TULARE	Region 10												
93666	TULARE	Region 10												
93670	TULARE	Region 10												
93673	TULARE	Region 10												
95305	TUOLUMNE	Region 1												
95309	TUOLUMNE	Region 1												
95310	TUOLUMNE	Region 1												
95314	TUOLUMNE	Region 1												
95321	TUOLUMNE	Region 1												
95327	TUOLUMNE	Region 1												
95335	TUOLUMNE	Region 1												
95346	TUOLUMNE	Region 1												
95347	TUOLUMNE	Region 1												
95364	TUOLUMNE	Region 1												
95370	TUOLUMNE	Region 1												
95372	TUOLUMNE	Region 1												
95373	TUOLUMNE	Region 1												
95375	TUOLUMNE	Region 1												
95379	TUOLUMNE	Region 1												
95383	TUOLUMNE	Region 1												
91319	VENTURA	Region 12												
91320	VENTURA	Region 12												
91358	VENTURA	Region 12												
91359	VENTURA	Region 12												
91360	VENTURA	Region 12												
91361	VENTURA	Region 12												
91362	VENTURA	Region 12												
91377	VENTURA	Region 12												
93001	VENTURA	Region 12												
93002	VENTURA	Region 12												
93003	VENTURA	Region 12												
93004	VENTURA	Region 12												
93005	VENTURA	Region 12												
93006	VENTURA	Region 12												
93007	VENTURA	Region 12												
93009	VENTURA	Region 12												
93010	VENTURA	Region 12												
93011	VENTURA	Region 12												
93012	VENTURA	Region 12												
93015	VENTURA	Region 12												
93016	VENTURA	Region 12												
93020	VENTURA	Region 12												
93021	VENTURA	Region 12												
93022	VENTURA	Region 12												
93023	VENTURA	Region 12												
93024	VENTURA	Region 12												
93030	VENTURA	Region 12												
93031	VENTURA	Region 12												
93032	VENTURA	Region 12												
93033	VENTURA	Region 12												
93034	VENTURA	Region 12												
93035	VENTURA	Region 12												
93036	VENTURA	Region 12												
93040	VENTURA	Region 12												
93041	VENTURA	Region 12												
93042	VENTURA	Region 12												
93043	VENTURA	Region 12												
93044	VENTURA	Region 12												
93060	VENTURA	Region 12												
93061	VENTURA	Region 12												
93062	VENTURA	Region 12												
93063	VENTURA	Region 12												
93064	VENTURA	Region 12												
93065	VENTURA	Region 12												
93066	VENTURA	Region 12												
93094	VENTURA	Region 12												
93099	VENTURA	Region 12												
95605	YOLO	Region 3												
95606	YOLO	Region 3												
95607	YOLO	Region 3												
95612	YOLO	Region 3												
95616	YOLO	Region 3												
95617	YOLO	Region 3												
95618	YOLO	Region 3												
95627	YOLO	Region 3												
95637	YOLO	Region 3												
95645	YOLO	Region 3												
95653	YOLO	Region 3												
95679	YOLO	Region 3												

			Licensed Geographic Service Area				Licensed Geographic Service Area for Proposed Exchange Products				Planned Changes in 2013 (Indicate any regions where expansion or contraction is in the process of being filed)			
Zip Code	County	Rating Region (Pre-populated)	HMO	PPO	Narrow	Other	Standardized Plan 1(Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan	Standardized Plan 1 (Copay)	Standardized Plan 2 (Coinsurance)	HSA Plan	Alternate Plan
95691	YOLO	Region 3												
95694	YOLO	Region 3												
95695	YOLO	Region 3												
95697	YOLO	Region 3												
95698	YOLO	Region 3												
95776	YOLO	Region 3												
95798	YOLO	Region 3												
95799	YOLO	Region 3												
95937	YOLO	Region 3												
95692	YUBA	Region 1												
95901	YUBA	Region 1												
95903	YUBA	Region 1												
95918	YUBA	Region 1												
95919	YUBA	Region 1												
95922	YUBA	Region 1												
95925	YUBA	Region 1												
95935	YUBA	Region 1												
95961	YUBA	Region 1												
95962	YUBA	Region 1												
95972	YUBA	Region 1												

California Health Benefit Exchange
Qualified Health Plans Solicitation
Appendix II, Addendum 1, Attachment 1.6 - Delivery System Reform

Indicate the geography and contracted providers engaged in delivery system initiatives, and expected availability for the SHOP and Individual Exchange enrollees. The 19 regions are defined based on recent California legislation and shown in the linked attachment. For the columns indicating the number of members and physicians included, report data as of January 1, 2013; if current data are not available, report data as of September 30, 2012.

Rating Region	Type of Initiative *(see definitions below)	Geographic Availability	Product Availability	List partner organizations (medical groups and hospitals)	Number of members included in the program	Number of primary care physicians included in the program	Number of specialists included in the program
Region 1	*Multi, Choice* Accountable Care Organization Primary Care Medical Home	*Single, Pull-down list* Full Region Partial Region Not Offered	*Single, Pull-down list* SHOP Individual Not Available to the Exchange May be available to the Exchange after 2015	*Detail box 500 words*	*Numeric*	*Numeric*	*Numeric*
Region 2							
Region 3							
Region 4							
Region 5							
Region 6							
Region 7							
Region 8							
Region 9							
Region 10							
Region 11							
Region 12							
Region 13							
Region 14							
Region 15							
Region 16							
Region 17							
Region 18							
Region 19							

*Accountable Care Organizations means that there is both upside and downside risk for participants with gainsharing available to purchasers or consumers
*Primary Care Medical Home means a targeted effort to support practice transformation and steerage of members to PCMH-designated providers

California Health Benefit Exchange
Qualified Health Plans Solicitation
Appendix II, Addendum 1, Attachment 1.7 - SHOP Alternate Plan Design

Input the cost sharing amounts that describe the enrollee's out-of-pocket costs for each benefit category. List any exclusions in the column on the right.

Bidder is offering a Standard Plan
across all metal levels.
Yes
No

		Single pull-down list Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	*Single pull-down list* Offered Not Offered	
		Silver Alternate Plan	**Silver Alternate Plan**	**Platinum Alternate Plan (Optional)**	**Platinum Alternate Plan (Optional)**	**Gold Alternate Plan (Optional)**	**Gold Alternate Plan (Optional)**	**Bronze Alternate Plan (Optional)**	**Bronze Alternate Plan (Optional)**	**Provide additional detail including any exclusions**
		Participating Providers	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	
12/28/2012										
Estimated Actuarial Value		%	%	%	%	%	%	%	%	
Overall deductible		$	$	$	$	$	$	$	$	
Other deductibles for specific services		$	$	$	$	$	$	$	$	
Facility-related Services		$	$	$	$	$	$	$	$	
Brand Drugs		$	$	$	$	$	$	$	$	
Dental		$	$	$	$	$	$	$	$	
Out–of–pocket limit on expenses		$	$	$	$	$	$	$	$	
Service Type	**Professional/ Hospital**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Provide additional detail including any exclusions**
Visit to a health care provider's office or clinic										
Primary care visit to treat an injury or illness (*deductible waived for first visit except Non-Par Providers or HSA plans--see footnote*)		Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	*text box, 100 words - replicate below*
Specialist visit		Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	
Other practitioner office visit										
Preventive care/ screening/ immunization										
Tests										
Diagnostic test (x-ray, blood work)										
Imaging (CT/PET scans, MRIs)										
Drugs to treat illness or condition										
Generic drugs										
Preferred brand drugs										
Non-preferred brand drugs										
Specialty drugs										
Outpatient surgery										
Facility fee (e.g., ambulatory surgery center)										

		Silver Alternate Plan	Silver Alternate Plan	Platinum Alternate Plan (Optional)	Platinum Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Gold Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Bronze Alternate Plan (Optional)	Provide additional detail including any exclusions
		Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	
Physician/surgeon fees										
Need immediate attention										
Emergency room services										
Emergency medical transportation										
Urgent care										
Hospital stay										
Facility fee (e.g., hospital room)										
Physician/surgeon fee										
Mental health, behavioral health, or substance abuse needs										
Mental/Behavioral health outpatient services										
Mental/Behavioral health inpatient services										
Substance use disorder outpatient services										
Substance use disorder inpatient services										
Pregnancy										
Prenatal and postnatal care										
Delivery and all inpatient services	Professional									
Delivery and all inpatient services	Hospital									
Help recovering or other special health needs										
Home health care										
Rehabilitation services										
Habilitation services										
Skilled nursing care										
Durable medical equipment										
Hospice service										
Child needs dental or eye care										
Eye exam (*deductible waived*)										
Glasses										
Dental check-up - Preventive and Diagnostic Services (*deductible waived*)										
Dental Basic Services										
Dental Restorative and Orthodontia Services										

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 1, Attachment 1.8 - Individual Alternate Plan Design

Input the cost sharing amounts that describe the enrollee's out-of-pocket costs for each benefit category. List any exclusions in the column on the right.

Bidder is offering a Standard Plan
across all metal levels.
Yes
No

		Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	Single pull-down list Offered Not Offered	
		Silver Alternate Plan	**Silver Alternate Plan**	**Platinum Alternate Plan (Optional)**	**Platinum Alternate Plan (Optional)**	**Gold Alternate Plan (Optional)**	**Gold Alternate Plan (Optional)**	**Bronze Alternate Plan (Optional)**	**Bronze Alternate Plan (Optional)**	**Provide additional detail including any exclusions**
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS **12/28/2012**		**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**	
Estimated Actuarial Value		%	%	%	%	%	%	%	%	
Overall deductible		$	$	$	$	$	$	$	$	
Other deductibles for specific services		$	$	$	$	$	$	$	$	
Facility-related Services		$	$	$	$	$	$	$	$	
Brand Drugs		$	$	$	$	$	$	$	$	
Dental		$	$	$	$	$	$	$	$	
Out–of–pocket limit on expenses		$	$	$	$	$	$	$	$	
Service Type	**Professional/ Hospital**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Member Cost Share**	**Provide additional detail including any exclusions**
Visit to a health care provider's office or clinic										
Primary care visit to treat an injury or illness (*deductible waived for first visit except Non-Par Providers or HSA plans--see footnote*)		Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	Drop down - Value entered as ____% or $____	text box, 100 words - replicate below
Specialist visit		Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	Repeat below	
Other practitioner office visit										
Preventive care/ screening/ immunization										
Tests										
Diagnostic test (x-ray, blood work)										
Imaging (CT/PET scans, MRIs)										
Drugs to treat illness or condition										
Generic drugs										
Preferred brand drugs										
Non-preferred brand drugs										
Specialty drugs										
Outpatient surgery										
Facility fee (e.g., ambulatory surgery center)										

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Alternate Plan Participating Providers	Silver Alternate Plan Non-Participating Providers	Platinum Alternate Plan (Optional) Participating Providers	Platinum Alternate Plan (Optional) Non-Participating Providers	Gold Alternate Plan (Optional) Participating Providers	Gold Alternate Plan (Optional) Non-Participating Providers	Bronze Alternate Plan (Optional) Participating Providers	Bronze Alternate Plan (Optional) Non-Participating Providers	Provide additional detail including any exclusions
Physician/surgeon fees										
Need immediate attention										
Emergency room services										
Emergency medical transportation										
Urgent care										
Hospital stay										
Facility fee (e.g., hospital room)										
Physician/surgeon fee										
Mental health, behavioral health, or substance abuse needs										
Mental/Behavioral health outpatient services										
Mental/Behavioral health inpatient services										
Substance use disorder outpatient services										
Substance use disorder inpatient services										
Pregnancy										
Prenatal and postnatal care										
Delivery and all inpatient services	Professional									
Delivery and all inpatient services	Hospital									
Help recovering or other special health needs										
Home health care										
Rehabilitation services										
Habilitation services										
Skilled nursing care										
Durable medical equipment										
Hospice service										
Child needs dental or eye care										
Eye exam (*deductible waived*)										
Glasses										
Dental check-up - Preventive and Diagnostic Services (*deductible waived*)										
Dental Basic Services										
Dental Restorative and Orthodontia Services										

California Health Benefit Exchange QHP Solicitation

Appendix II, Addendum 2 - Provider Network and Essential Community Providers

The following attachments are due February 15, 2013 at close of business.

Attachment
2.1 - Contracted Providers by County as of January 1, 2013 *(Submitted as an Excel attachment)*
2.2 - Contracted Facilities by County as of January 1, 2013 *(Submitted as an Excel attachment)*
2.3 - Number and Percent of Contracted 340B Providers by County for Standard Plan 1 (Copay)
2.4 - Number and Percent of Contracted 340B Providers by County for Standard Plan 2 (Coinsurance)
2.5 - Number and Percent of Contracted 340B Providers by County for Catastrophic Plan
2.6 - Number and Percent of Contracted 340B Providers by County for HSA Plan
2.7 - Number and Percent of Contracted 340B Providers by County for Alternate Plan

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.1 - Contracted Providers by County as of January 1, 2013

Using the following format, attach a list of the Bidder's contracted provider network.

Variable Name	Description	Type	Length
PROV_ID	Plan-assigned Provider number	Chr	20
PROV_FNAME	Provider First Name	Chr	20
PROV-MI	Provider Middle Initial	Chr	6
PROV_LNAME	Provider Last Name	Chr	30
PROV_SUFFIX	Provider Degrees (MD, DO, NP, LSW etc)	Chr	20
PROV_ORG	Medical Group or Community Health Center Name	Chr	40
DMHC_ID	DMHC number for Medical Group	Chr	10
PROV_SUB_NAME	Entity Sub-Division Name	Chr	30
PROV_ADDR	Entity Street Address	Chr	30
PROV_ADDR2	2nd address line, if needed	Chr	30
PROV_CITY	Entity City	Chr	20
PROV_ZIP	Entity Zipcode	Chr	10
PROV_COUNTY	Entity County	Chr	20
340B_ID	340B Provider ID	Chr	35
NPI	National Provider ID	Chr	20
LICENSE #	License Number	Chr	25
TYPE_CODE	Entity Type Code	Chr	37
PRIMARY_CARE	Y/N If provider is a primary care provider	Chr	1
PRACTICE_OPEN	Y/N if provider is accepting new patients	Chr	1
HMO CONTRACT FLAG	Y/N	Chr	1
PPO CONTRACT FLAG	Y/N	Chr	1
ACO CONTRACT FLAG	Y/N	Chr	1
PCMH Certified	Y/N	Chr	1
NARROW NETWORK CONTRACT	Y/N	Chr	1
TRIBAL_URBAN_INDIAN	Y/N if provider is a federally designated 638 Tribal Health Programs or Title V Urban Indian Health Organization*	Chr	1
SCHOOL_CLN	Y/N if provider is a full-service school-based clinic*	Chr	1
FQHC	Y/N if Federally Qualified Health Center*	Chr	1
MCAL_EHR	Y/N if Provider has approved application for the HI-TECH Medi-Cal Electronic Health Record Incentive Program*	Chr	1
1204a	Y/N if Provider is licensed as either a “community clinic or “free clinic”, under the California Health and Safety Code section 1204(a) and (2), or is a community clinic or free clinic exempt from licensure under Section 1206*	Chr	1
HIGH_PERF_FLAG	Y/N If Issuer uses a quality designation program, indicate if the provider has a quality designation	Chr	1
MCAL_MGD_CARE	Y/N If Plan contracts with both commercial and Medi-Cal Managed Care, indicate if the provider is available in the Medi-Cal Managed Care Network	Chr	1
STD_PLAN_1	Y/N If provider is in the network supporting Exchange Standard Plan 1	Chr	1
STD_PLAN_2	Y/N If provider is in the network supporting Exchange Standard Plan 2	Chr	1
Alt Plan Contract Flag	Y/N If Issuer is submitting an Alternate Plan design, indicate if this provider is part of that network	Chr	1
PATIENT_VOL	If provider is a primary care provider, number of patients currently assigned, if PCP offered through HMO Product	Num	4

*Provider lists are provided through the "Essential Community Provider" document posted on the Exchange QHP Solicitation Web site:
http://www.healthexchange.ca.gov/Solicitations/Documents/Essential%20Community%20Providers.pdf

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.2 - Contracted Facilities by County as of January 1, 2013

Using the following format, attach a list of the Bidder's contracted facility network.

Variable Name	Description	Type	Length
HOSP_ID	Plan-assigned ID number	Chr	20
ORG	Facility Name	Chr	40
ADDR	Entity Street Address	Chr	30
ADDR2	Address line 2 (if needed)	Chr	30
CITY	Entity City	Chr	20
ZIP	Entity Zipcode	Chr	10
COUNTY	Entity County	Chr	20
340B_ID	340B Provider ID	Chr	35
DSH	Y/N if Disproportionate Share Status	Chr	20
LICENSE #	License Number	Chr	20
HMO CONTRACT FLAG	Y/N	Chr	1
PPO CONTRACT FLAG	Y/N	Chr	1
ACO CONTRACT FLAG	Y/N	Chr	1
NARROW NETWORK CONTRACT	Y/N	Chr	1
HIGH_PERF_FLAG	Y/N If Issuer uses a quality designation program, indicate if the facility has a quality designation	Chr	1
MCAL_MGD_CARE	Y/N If Plan contracts with both commercial and Medi-Cal Managed Care, indicate if the facility is available in the Medi-Cal Managed Care Network	Chr	1
STD_PLAN_1	Y/N If facility is in the network supporting Exchange Standard Plan 1	Chr	1
STD_PLAN_2	Y/N If facility is in the network supporting Exchange Standard Plan 2	Chr	1
Alt Plan Contract Flag	Y/N If Issuer is submitting an Alternate Plan design, indicate if this facility is part of that network	Chr	1

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.3 - Number and Percent of Contrac

for Standard Plan 1 (Copay Design)

Standard #1			
County	**Number of 340B Providers**	**Number of Contracts**	**% of 340B Providers**
ALAMEDA			
ALPINE			
AMADOR			
BUTTE			
CALAVERAS			
COLUSA			
CONTRA COSTA			
DEL NORTE			
EL DORADO			
FRESNO			
GLENN			
HUMBOLDT			
IMPERIAL			
INYO			
KERN			
KINGS			
LAKE			
LASSEN			
LOS ANGELES			
MADERA			
MARIN			
MARIPOSA			
MENDOCINO			
MERCED			
MODOC			
MONO			
MONTEREY			
NAPA			
NEVADA			
ORANGE			
PLACER			
PLUMAS			
RIVERSIDE			
SACRAMENTO			
SAN BENITO			
SAN BERNARDINO			
SAN DIEGO			
SAN FRANCISCO			
SAN JOAQUIN			
SAN LUIS OBISPO			
SAN MATEO			
SANTA BARBARA			
SANTA CLARA			
SANTA CRUZ			
SHASTA			
SIERRA			
SISKIYOU			
SOLANO			
SONOMA			
STANISLAUS			
SUTTER			
TEHAMA			
TRINITY			
TULARE			
TUOLUMNE			
VENTURA			
YOLO			
YUBA			

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.4 - Number and Percent of Contrac

for Standard Plan 2 (Coinsurance Design)

Standard #2			
County	**Number of 340B Providers**	**Number of Contracts**	**% of 340B Providers**
ALAMEDA			
ALPINE			
AMADOR			
BUTTE			
CALAVERAS			
COLUSA			
CONTRA COSTA			
DEL NORTE			
EL DORADO			
FRESNO			
GLENN			
HUMBOLDT			
IMPERIAL			
INYO			
KERN			
KINGS			
LAKE			
LASSEN			
LOS ANGELES			
MADERA			
MARIN			
MARIPOSA			
MENDOCINO			
MERCED			
MODOC			
MONO			
MONTEREY			
NAPA			
NEVADA			
ORANGE			
PLACER			
PLUMAS			
RIVERSIDE			
SACRAMENTO			
SAN BENITO			
SAN BERNARDINO			
SAN DIEGO			
SAN FRANCISCO			
SAN JOAQUIN			
SAN LUIS OBISPO			
SAN MATEO			
SANTA BARBARA			
SANTA CLARA			
SANTA CRUZ			
SHASTA			
SIERRA			
SISKIYOU			
SOLANO			
SONOMA			
STANISLAUS			
SUTTER			
TEHAMA			
TRINITY			
TULARE			
TUOLUMNE			
VENTURA			
YOLO			
YUBA			

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.5 - Number and Percent of Contrac

for Catastrophic Plan

Catastrophic			
County	Number of 340B Providers	Number of Contracts	% of 340B Providers
ALAMEDA			
ALPINE			
AMADOR			
BUTTE			
CALAVERAS			
COLUSA			
CONTRA COSTA			
DEL NORTE			
EL DORADO			
FRESNO			
GLENN			
HUMBOLDT			
IMPERIAL			
INYO			
KERN			
KINGS			
LAKE			
LASSEN			
LOS ANGELES			
MADERA			
MARIN			
MARIPOSA			
MENDOCINO			
MERCED			
MODOC			
MONO			
MONTEREY			
NAPA			
NEVADA			
ORANGE			
PLACER			
PLUMAS			
RIVERSIDE			
SACRAMENTO			
SAN BENITO			
SAN BERNARDINO			
SAN DIEGO			
SAN FRANCISCO			
SAN JOAQUIN			
SAN LUIS OBISPO			
SAN MATEO			
SANTA BARBARA			
SANTA CLARA			
SANTA CRUZ			
SHASTA			
SIERRA			
SISKIYOU			
SOLANO			
SONOMA			
STANISLAUS			
SUTTER			
TEHAMA			
TRINITY			
TULARE			
TUOLUMNE			
VENTURA			
YOLO			
YUBA			

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.6 - Number and Percent of Contrac

for HSA Plan

HSA			
County	Number of 340B Providers	Number of Contracts	% of 340B Providers
ALAMEDA			
ALPINE			
AMADOR			
BUTTE			
CALAVERAS			
COLUSA			
CONTRA COSTA			
DEL NORTE			
EL DORADO			
FRESNO			
GLENN			
HUMBOLDT			
IMPERIAL			
INYO			
KERN			
KINGS			
LAKE			
LASSEN			
LOS ANGELES			
MADERA			
MARIN			
MARIPOSA			
MENDOCINO			
MERCED			
MODOC			
MONO			
MONTEREY			
NAPA			
NEVADA			
ORANGE			
PLACER			
PLUMAS			
RIVERSIDE			
SACRAMENTO			
SAN BENITO			
SAN BERNARDINO			
SAN DIEGO			
SAN FRANCISCO			
SAN JOAQUIN			
SAN LUIS OBISPO			
SAN MATEO			
SANTA BARBARA			
SANTA CLARA			
SANTA CRUZ			
SHASTA			
SIERRA			
SISKIYOU			
SOLANO			
SONOMA			
STANISLAUS			
SUTTER			
TEHAMA			
TRINITY			
TULARE			
TUOLUMNE			
VENTURA			
YOLO			
YUBA			

California Health Benefit Exchange

Qualified Health Plans Solicitation

Appendix II, Addendum 2, Attachment 2.7 - Number and Percent of Contrac

for Alternate Plan

Alternate Plan			
County	Number of 340B Providers	Number of Contracts	% of 340B Providers
ALAMEDA			
ALPINE			
AMADOR			
BUTTE			
CALAVERAS			
COLUSA			
CONTRA COSTA			
DEL NORTE			
EL DORADO			
FRESNO			
GLENN			
HUMBOLDT			
IMPERIAL			
INYO			
KERN			
KINGS			
LAKE			
LASSEN			
LOS ANGELES			
MADERA			
MARIN			
MARIPOSA			
MENDOCINO			
MERCED			
MODOC			
MONO			
MONTEREY			
NAPA			
NEVADA			
ORANGE			
PLACER			
PLUMAS			
RIVERSIDE			
SACRAMENTO			
SAN BENITO			
SAN BERNARDINO			
SAN DIEGO			
SAN FRANCISCO			
SAN JOAQUIN			
SAN LUIS OBISPO			
SAN MATEO			
SANTA BARBARA			
SANTA CLARA			
SANTA CRUZ			
SHASTA			
SIERRA			
SISKIYOU			
SOLANO			
SONOMA			
STANISLAUS			
SUTTER			
TEHAMA			
TRINITY			
TULARE			
TUOLUMNE			
VENTURA			
YOLO			
YUBA			

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2008)

See SAM Section 6601 - 6616 for Instructions and Code Citations

DEPARTMENT NAME	CONTACT PERSON	TELEPHONE NUMBER
California Health Benefit Exchange	Brandon Ross	916-323-3471
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400		**NOTICE FILE NUMBER**
Title 10: Process for Selecting Qualified Health Plans for the Exchange		Z

ECONOMIC IMPACT STATEMENT

A. ESTIMATED PRIVATE SECTOR COST IMPACTS (Include calculations and assumptions in the rulemaking record.)

1. Check the appropriate box(es) below to indicate whether this regulation:

- [x] a. Impacts businesses and/or employees
- [ ] b. Impacts small businesses
- [ ] c. Impacts jobs or occupations
- [ ] d. Impacts California competitiveness
- [ ] e. Imposes reporting requirements
- [ ] f. Imposes prescriptive instead of performance
- [ ] g. Impacts individuals
- [ ] h. None of the above (Explain below. Complete the Fiscal Impact Statement as appropriate.)

h. (cont.) _____

(If any box in Items 1 a through g is checked, complete this Economic Impact Statement.)

2. Enter the total number of businesses impacted: Unknown Describe the types of businesses (Include nonprofits.): Health Insurance Providers

Enter the number or percentage of total businesses impacted that are small businesses: 0%

3. Enter the number of businesses that will be created: N/A eliminated: N/A

Explain: _____

4. Indicate the geographic extent of impacts: [x] Statewide [ ] Local or regional (List areas.): _____

5. Enter the number of jobs created: N/A or eliminated: N/A Describe the types of jobs or occupations impacted: _____

6. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here?

[ ] Yes [x] No If yes, explain briefly: _____

B. ESTIMATED COSTS (Include calculations and assumptions in the rulemaking record.)

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ Unknown

a. Initial costs for a small business: $ N/A Annual ongoing costs: $ _____ Years: _____

b. Initial costs for a typical business: $ Unknown Annual ongoing costs: $ Unkown Years: Unk

c. Initial costs for an individual: $ _____ Annual ongoing costs: $ _____ Years: _____

d. Describe other economic costs that may occur: Administrative Overhead costs

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

2. If multiple industries are impacted, enter the share of total costs for each industry: _____

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. (Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.): $ Unknown

4. Will this regulation directly impact housing costs? ☐ Yes ☑ No If yes, enter the annual dollar cost per housing unit: _____ and the number of units: _____

5. Are there comparable Federal regulations? ☐ Yes ☑ No Explain the need for State regulation given the existence or absence of Federal regulations: _____

Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ _____

C. ESTIMATED BENEFITS (Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. Briefly summarize the benefits that may result from this regulation and who will benefit: Health Insurance Providers will have more individuals sign up and pay for health insurance. Individuals will have another opportunity to purchase health insurance at affordable prices. Health Care Providers will see less uninsured patients. (See Attachment A)

2. Are the benefits the result of : ☐ specific statutory requirements, or ☑ goals developed by the agency based on broad statutory authority?
Explain: The regulations create an indirect benefit to the state. (See Attachment A)

3. What are the total statewide benefits from this regulation over its lifetime? $ Unkown

D. ALTERNATIVES TO THE REGULATION (Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.)

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: _____

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

Regulation:	Benefit: $ Unkown	Cost: $ Unknown
Alternative 1:	Benefit: $	Cost: $
Alternative 2:	Benefit: $	Cost: $

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: _____

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ Yes ☐ No

Explain: _____

E. MAJOR REGULATIONS (Include calculations and assumptions in the rulemaking record.) Cal/EPA boards, offices, and departments are subject to the following additional requirements per Health and Safety Code section 57005.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

1. Will the estimated costs of this regulation to California business enterprises exceed $10 million ? ☐ Yes ☑ No (If No, skip the rest of this section.)

2. Briefly describe each equally as an effective alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

   Alternative 1: _____

   Alternative 2: _____

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

   Regulation: $ _____ Cost-effectiveness ratio: $ _____

   Alternative 1: $ _____ Cost-effectiveness ratio: $ _____

   Alternative 2: $ _____ Cost-effectiveness ratio: $ _____

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT (Indicate appropriate boxes1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code. Funding for this reimbursement:

☐ a. is provided in _____, Budget Act of _____ or Chapter _____, Statutes of _____

☐ b. will be requested in the _____ (FISCAL YEAR) Governor's Budget for appropriation in Budget Act of _____

☐ 2. Additional expenditures of approximately $ _____ in the current State Fiscal Year which are not reimbursable by the State pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code because this regulation:

☐ a. implements the Federal mandate contained in _____

☐ b. implements the court mandate set forth by the _____

court in the case of _____ vs. _____

☐ c. implements a mandate of the people of this State expressed in their approval of Proposition No. _____ at the _____ (DATE) election;

☐ d. is issued only in response to a specific request from the _____

_____, which is/are the only local entity(s) affected;

☐ e. will be fully financed from the _____ (FEES, REVENUE, ETC.) authorized by Section

_____ of the _____ Code;

☐ f. provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each such unit;

☐ g. creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Savings of approximately $ _____ annually.

☐ 4. No additional costs or savings because this regulation makes only technical, non-substantive or clarifying changes to current law regulations.

ECONOMIC AND FISCAL IMPACT STATEMENT cont. (STD. 399, Rev. 12/2008)

☑ 5. No fiscal impact exists because this regulation does not affect any local entity or program.

☐ 6. Other.

B. FISCAL EFFECT ON STATE GOVERNMENT (Indicate appropriate boxes 1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☐ 1. Additional expenditures of approximately $ _____ in the current State Fiscal Year. It is anticipated that State agencies will:

☐ a. be able to absorb these additional costs within their existing budgets and resources.

☐ b. request an increase in the currently authorized budget level for the _____ fiscal year.

☐ 2. Savings of approximately $ _____ in the current State Fiscal Year.

☑ 3. No fiscal impact exists because this regulation does not affect any State agency or program.

☐ 4. Other.

C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS (Indicate appropriate boxes1 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.)

☑ 1. Additional expenditures of approximately $ $852,000 in the current State Fiscal Year.

☐ 2. Savings of of approximately $ _____ in the current State Fiscal Year.

☐ 3. No fiscal impact exists because this regulation does not affect any federally funded State agency or program.

☑ 4. Other. Assumptions and fiscal statement for subsequent years attached.

FISCAL OFFICER SIGNATURE		DATE 4/18/2013
AGENCY SECRETARY [1] APPROVAL/CONCURRENCE		DATE 6/25/13
DEPARTMENT OF FINANCE [2] APPROVAL/CONCURRENCE	PROGRAM BUDGET MANAGER	DATE

1. *The signature attests that the agency has completed the STD.399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or department not under an Agency Secretary must have the form signed by the highest ranking official in the organization.*

2. *Finance approval and signature is required when SAM sections 6601-6616 require completion of Fiscal Impact Statement in the STD.399.*

California Health Benefit Exchange
Economic Impact Statement
Establish Process for Selecting Qualified Health Plans

Purpose

The proposed regulation would make specific the process for health insurers to submit qualified health plans (QHP) for both individual and Small Business Health Options Program (SHOP) Exchanges.

Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a qualified health benefit exchange. (California Government Code § 100500 et seq.; Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Effective January 1, 2014, the California Health Benefit Exchange (Exchange) will be offering a statewide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health insurance in the private market, with enrollment beginning in fall 2013. Although the focus of the Exchange will be on individuals and small businesses who qualify for tax credits and subsidies under the ACA, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with 50 or fewer employees.

The Exchange's policies are derived from the Federal Affordable Care Act, which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Health Plans that will be offered in the Exchange.

Economic Impact

The proposed regulations require Health Insurance Issuers (Issuers) to submit bids, only if the Issuer would like to offer, market, and sell QHPs through the Exchange.

While it is reasonable to assume the Issuers will have some administrative overhead costs due to the submission process, it would be inaccurate to project the direct costs associated to the bidding process,

as well as indirect costs, due to several unknown variables such as: the number of issuers that will submit a bid, how many employees will be assigned to the bid process, the level of staff, the time each staff will work on the task, the supplies used to complete process, etc.

However, it is as equally reasonable to assume that any Issuer planning to submit a bid will account for all administrative overhead costs, including costs due to the process, in their proposal and recoup those costs plus profit by selling their health insurance through the Exchange.

Economic Benefits

The proposed regulations will not benefit the State of California by increasing revenues or cutting expenses, but it will provide a significant benefit to the State as a whole. The regulations will be the basis for establishing a fair and competitive market place where millions of Californians, who currently do not have or cannot afford quality health care services, can purchase needed and quality health insurance. This process will significantly reduce the burden that the uninsured population places on state run hospitals and health care providers.

Conclusion

The proposed regulations may have a minimal economic impact on Health Insurance Issuers administrative costs, but since submitting a bid to join the Exchange's new marketplace is voluntary we can assume that any Issuer that submits a bid will receive a financial gain that outweighs the initial administrative costs and therefore justifies a positive economic impact on the State of California.

Health Plan Management Unit - Total Projected Federal Costs

Expenditure Category	FY 2012/13	FY 2013/14	FY 2014/15 *	Total
Salaries	253,207	1,640,004	820,002	1,893,211
Benefits	79,409	639,612	319,806	719,021
OE&E	39,046	254,680	127,340	293,726
Sub-Total	371,662	2,534,296	1,267,148	2,905,958
Contractual	525,000	631,250	315,625	1,156,250
Total	**$ 896,662**	**$ 3,165,546**	**$ 1,582,773**	**$ 4,062,208**

** The amount reflected for FY 2014/15 shows 6 months of projected costs (July 2014 - Dec 2014), which represents the duration of federal funding. The remainder of FY 2014/15 (Jan 2015 - June 2015) will be supported by Fund 3175 - California Health Trust Fund, and not federal funds.*

Projected Federal Costs Associated with the Process for Selecting Qualified Health Plans

Percent of Health Plan Mgmt Unit's Workload	*95%*	*10%*	*0%*	
Expenditure Category	FY 2012/13	FY 2013/14	FY 2014/15	Total
Salaries	240,547	164,000	-	404,547
Benefits	75,439	63,961	-	139,400
OE&E	37,094	25,468	-	62,562
Sub-Total	353,079	253,430	-	606,509
Contractual	498,750	63,125	-	561,875
Total	**$ 851,829**	**$ 316,555**	**$ -**	**$ 1,168,384**

Assumption: The majority of time needed for the Process for Selecting Qualified Health Plans is in the initial stages of the development of the California Health Benefit Exchange. Thus, in FY 2012/13 the workload for the Health Plan Management unit related to this regulation is 95%, and only 10% in FY 2013/14.